# Maternal and Child Health Services
# Title V Block Grant

# State Narrative for Alaska

## Application for 2011
## Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

# Table of Contents

# I. General Requirements

## A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
***An attachment is included in this section.***

## B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

## C. Assurances and Certifications

The Commissioner of Health and Social Services signs the Title V application with the required Assurances and Certifications. These are on file at our office located a 3601 C Street Suite 322, Anchorage, Alaska 99503.

## D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

## E. Public Input

Since the FY 2011 Block Grant coincides with the 2010 Needs Assessment, a full description of the Title V public participation program can be found in the 2010 Needs Assessment report. A summary will be presented here.

WCFH, the Title V agency, relies on an on-going, continuous engagement with stakeholders for meaningful public participation. WCFH-established program advisory committees meet on a regular basis throughout the year. In addition, all the agencies within the Department of Health and Social Services who offer MCH services, including WCFH, maintain web pages of their programs. The web sites include contact information.

For the 2010 Needs Assessment, WCFH held a workshop on February 19, 2010. Stakeholder input was obtained by using a collaborative thinking strategy called the World Café conversation. WCFH also conducted SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses with several program advisory committees. This included a mini-summit of the teen advisory group, the Youth Alliance for Healthy Alaskans, on teen pregnancy prevention. Needs assessments conducted by the Adolescent Health program manager and the School Nurse consultant were incorporated into the planning process. This included information from a survey of adults and teens in northwestern Alaska.

Public comments are routinely solicited during community visits by program managers. New research for this year is a qualitative analysis of comments from PRAMS surveys. While the analysis was not available for this Needs Assessment, the data will be very useful to inform future activities in the Perinatal Health program.

# II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

***An attachment is included in this section.***

## C. Needs Assessment Summary

State priorities for 2010 - 2015 are:

1. Reduce substance abuse among families, including alcohol, tobacco and drugs.
2. Reduce child maltreatment and bullying.
3. Collaborate with families to work toward a system of integrated services for families with infants, children, and teens, and especially those with special health care needs..
4. Reduce the risks associated with unintended pregnancy and teen pregnancy.
5. Reduce dental caries in children 0 - 21 years of age.
6. Reduce intimate partner violence (IPV) including teen dating violence.
7. Reduce preventable post-neonatal mortality due to SIDS/asphyxia.
8. Support communities to increase family and youth resiliency.
9. Reduce the prevalence of obesity and overweight throughout the lifespan.
10. Increase universal screening for post partum depression in women.
11. Strengthen quality school-based health care and health promotion.
12. Implement standardized screening for developmental delay and behavioral health in children 0 - 21 years.
13. Develop capacity to help families navigate the health care system.
14. Acknowledge the importance of men in MCH programs.
15. Reduce late preterm cesarean sections.

In many ways, state priorities have not changed since the 2005 Needs Assessment. Issues of mental health, education, family resiliency and delivery of health care in rural areas are reflected in the state priorities concerning outcomes in substance abuse (#1), child maltreatment (#2), teen pregnancy (#4), intimate partner violence (#6), post-neonatal mortality (#7), chronic conditions (#5, #9), and post partum depression (#10).

New priorities focus on expanding access to services by increasing system efficiency (#3), increasing navigation assistance (#13), and promoting new systems (#11, #13). The State continues to expand implementation of the Early Childhood Comprehensive Systems which supports priorities 1,2, 3, and 8. The ECCS Plan was approved and adopted by the Department of Health and Social Services Commissioner and the Children's Policy Team.

The trend of increasing late preterm cesarean sections, similar to national trends, is an emerging issue (#15). Another emerging issue is incorporating a life course perspective and making the family unit (using very broad definitions of family) to focus on risk and protective factors of the family unit (#14).

The state's MCH program continued to grow in capacity in areas identified as priority in 2005. New programs implemented were the Adolescent Health Program, School Health Program, Perinatal Health Program, and the Pediatric Neurodevelopmental Outreach & Autism Screening Clinic, and the Parent Support Services programs. The Oral Health program has gained two additional staff members in the last five years. The MCH Epidemiology Unit has developed two new surveillance programs and hired additional staff to expand data surveillance and analysis capacity. These programs support priorities 1,3,4, 7, 9 which were carried over from the prior Needs Assessment. The new programs translate to increased ability to pursue grants, expand health education, assess needs, conduct data surveillance and special analysis, conduct program

evaluations, and create partnerships.

# III. State Overview

## A. Overview

Health care delivery

Health care delivery in Alaska consists of three separate systems. The Alaska Native Tribal Health Consortium (ANTHC) is a consortium of tribal entities that provides several levels of medical care: primary care at village clinics, primary and mid-level primary care at regional hospitals, and tertiary care at the Alaska Native Medical Center in Anchorage. ANTHC is funded by the Indian Health Service.

Health care services are very difficult to deliver in rural Alaska due to high transportation costs and lack of skilled resources in the small communities. A number of innovative systems has been created to overcome these barriers. The Community Health Aide Program is a network of about 500 Community Health Aides/Practitioners (CHAPs) who work in village clinics to provide basic health care services and referrals. The CHAP program is a vital link in the Alaska Tribal Health System. The Alaska Dental Health Aide Therapist Initiative, another ANTHC program, is conducted in collaboration with the University of Washington School of Medicine to train Alaska Native dental health technicians for community-level dental disease prevention in underserved Alaska Native populations. The Behavioral Health Aide Project aims to develop village-based behavioral health service capacity, focusing on prevention, early intervention and case management.

Two local governments, the Municipality of Anchorage and the North Slope Borough, operate local health departments with limited services. The State of Alaska, Department of Health and Social Services (DHSS), offers a wide range of health assessment and disease prevention services through 20 public health centers and itinerant nursing services.

Military hospitals and the Veteran's Administration serve the military population. Private sector physicians, health care providers and hospitals can serve any individual in the general population.

Maternal and child health (MCH) programs are managed by different sections within DHSS, Division of Public Health (DPH) and in other divisions within the Department of Health and Social Services. Within DPH, the Section of Women's, Children's and Family Health (WCFH) is the designated Title V agency. WCFH manages the following programs:

- Adolescent Health
- Women's Health
- Breast and Cervical Cancer Screening
- Oral Health (Adult and Child)
- Newborn Metabolic Screening
- Early Hearing and Detection Screening
- Title X-Family Planning
- Genetics and Metabolic Clinics
- Neurodevelopmental Outreach and Autism Screening Clinic
- Family Support Services
- Cleft Lip and Palate Clinics
- Perinatal Health
- School Nursing Consultation and School Health
- MCH Epidemiology
  - Pregnancy Risk Assessment Monitoring Survey (PRAMS)
  - Childhood Understanding Behavior Survey (CUBs)
  - Surveillance of Childhood Abuse and Neglect (Alaska SCAN)
  - Alaska Birth Defects and FASD registry
  - Maternal/Infant/ Child Death Review Committee

o Maternal -- Child Indicators Program

The Section of Chronic Disease Prevention and Health Promotion, also within DPH, manages several MCH programs:

- Family Violence and Prevention Project
- Alaska Safe Kids
- Obesity Prevention and Control
- School Health-Youth Risk Behavioral Survey
- Tobacco Prevention and Control

Some MCH programs are managed outside the Division of Public Health:

- EPSDT Outreach - Division of Health Care Services (Medicaid agency)
- Infant Learning/Early Intervention Program - Office of Children's Services
- Early Childhood Comprehensive Systems - Office of Children's Services
- Strengthening Families - Office of Children's Services
- WIC/Nutrition Programs- Division of Public Assistance

At one time these programs were housed within a single MCH section within DPH but were moved to other divisions in the early 2000s during a reorganization of the Department. Attempts to reunite MCH-related programs in the ensuing years were partially successful. The period between 2002 and 2009 was also one of administrative instability, marked by several turnovers at the Commissioner and the DPH division director level. Despite these organizational setbacks, the effort to increase intra-agency collaboration and grow MCH programs continued. These collaborations and ongoing program development continue today.

Principle Characteristics of the State of Alaska

Two defining characteristics of the state are the physical geography and the racial diversity of the population. Alaska is a large, sparsely populated state. The land mass of the state encompasses 571,951 square miles, averaging a population density of just 1.1 persons per square mile. This is the lowest population density of any state.

The 2008 Alaska resident population was estimated at 679,720, with 65% living in urban areas. Seventy percent were reported to be Caucasian alone, 16% Alaska Native/American Indian alone, 4% Black alone and 4% Hispanic. Twenty percent were reported to be Alaska Native/American Indian alone or in combination with another race category. This is an approximate proportion of the population eligible for ANTHC health services.

Of the people who dwell in rural areas, 82% are Alaska Natives. However, there is a trend of people moving from rural villages to regional centers and urban areas of the state. Looking at it another way, in 2000 58% of the statewide native population lived in rural areas and 42.3% lived in five urban Census Areas: the Municipality of Anchorage, the Matanuska-Susitna Borough, the Kenai Peninsula Borough, the Fairbanks North Star Borough and the City and Borough of Juneau. In other words, Alaska Natives made up 10.4% of the total urban population, double that of 1970 (part of the increase may be due to the fact that in the 2000 Census people were able to identify themselves as Natives of mixed race). It is predicted that the Alaska Native population will be increasingly urban with more than half living in urban areas by 2020.

Alaska is a fairly young state. In 2008 the median age was 33.5 years compared to 36.8 years for the U.S. Alaska Natives residents are even younger, on average than the state as a whole (26.4 years). Residents age 65 or older comprised 7.3% of the population of Alaska compared to 12.6% for the U.S. population. However, Alaska has the fastest-growing senior population in the U.S.

Factors Impacting Health Services Delivery

Approximately 75% of Alaskan communities, including the state's capital city of Juneau, are not connected to the road system. Accessing "nearby health services" or specialized health care means travel by commercial jet, small plane, the state marine ferry system, all terrain vehicles, small boats or snow machines. Some residents may travel distances equivalent to traveling from Washington, D.C. to New Orleans for even routine medical care. Moreover, severe weather can render travel impossible, creating especially critical situations in medical emergencies.

The geographic isolation of rural communities means significant challenges in assuring all MCH populations have access to routine preventive care, acute medical and specialty care. Specialty care, even in urban areas of the state, is limited. For example, the only Level III neonatal intensive care facility is located in Anchorage. Many communities have no facilities equipped for childbirth so pregnant women must leave their homes two weeks before their due date. Even well-child check-ups, prenatal exams and regular dental exams are difficult to provide. Recruiting and retaining physicians and primary health care providers for non-urban practices is also a barrier to providing health care services.

In 2009 the All Alaska Pediatric Partnership, in collaboration with the Alaska State Hospital and Nursing Home Association (ASHNHA) and the Alaska Mental Health Trust Authority (AMHTA), initiated the development of a pediatric subspecialty distribution plan for Alaska. The purpose of this plan was to identify and adopt a distribution strategy that provides the optimal balance of access to care for Alaska's children with an environment that is attractive to new providers, identifies the best use of outside specialists and primary care providers, and ensures volumes necessary to maintain skill sets and provide high-quality, safe care. The Title V Director was a member of the steering committee and the executive committee which had oversight and approval responsiblities. Findings related to service delivery were:

1. There is a growing and diversifying pediatric population and a need for a full range of subspecialty services, but volumes are insufficient to support.
2. Large and difficult geography limits access to subspecialty care, therefore, a reliance on air transport will continue. There are opportunities for telemedicine.
3. While existing resources are better than expected, gaps exist. The gaps can be fill with a coordinated approach of combining in-state and out-of-state resources.
4. No one delivery system can support a full range of subspecialists so collaboration among delivery systems is important.
5. Physician sustainability remains a challenge.

The full report, "Alaska Pedicatric Subspecialty Plan" is included as an attachment in Chapter III E.

Disparities

The largest differences in health trend status are between the native and non-native populations and between rural and urban populations. The majority of people living in rural areas are Alaska Native people. The health status of Alaska Native people is poorer than that of non-Native people in several domains. Living in remote communities with high unemployment rates, low income and high barriers to accessing health care services are contributing factors.

Significant improvements in health of Alaska Native people have been made since the 1970s. Large investments in infrastructure such as housing, safe water and sanitation facilities, village health clinics and regional hospitals contributed to significant improvements in life expectancy, infant mortality and infectious disease. However, research documents that continuing and significant disparities remain.

Compared to the non-Native population, the Alaska Native population has poorer health

outcomes in post-neonatal mortality; child, adolescent, teen (especially teen suicide), and female mortality; and childhood dental caries experience (among third graders). As the Alaska Native population becomes increasingly urban or adopts western lifestyles and diet, whether by choice or not, chronic diseases such as diabetes and heart disease are of increasing concern.

Cultural diversity among the non-Native population is increasing. About half the students in the Anchorage School District are ethnic minorities and they speak 94 different languages. A culturally diverse workforce that reflects the culture, language and respects the traditions of the populations is a crucial strategy for reducing health disparities.

Health coverage for uninsured women and children is an issue common to all states. Uninsured populations are less likely to access routine, preventive care and more likely to seek care when health problems are severe and require treatment. Lack of preventive health care is a major contributor to poor health status for MCH populations.

State priorities

The overriding theme for future direction for the Alaska Department of Health and Social Services is helping individuals and families create safe, healthy and productive communities. The Department's priorities outlined below span the breadth of the department and encompass the unique service-areas represented within. They include:

- Substance Abuse-Substance abuse affects every family and community in Alaska. It is a contributing factor in suicides, crime, unemployment, domestic violence, child abuse, school dropouts, juvenile delinquency, etc. We need to prevent, intervene early, treat and help people recover from substance abuse through public/private partnerships and long-term strategies;

- Health and Wellness-Many Alaskans lead less happy and less productive lives, and many die prematurely each year, because of disability and death caused by tobacco, alcohol abuse, injuries, obesity, diabetes, cancer, heart disease and sexually transmitted diseases. Most of these outcomes are attributable to personal choice involving diet, physical activity and tobacco use -- and are preventable. We can do a better job of screening, diagnosing and treating these conditions;

- Health Care Reform-Alaska's health care system continues to be fragmented and uncoordinated and doesn't produce the kinds of outcomes we expect. By strategically focusing on care management, reforming Medicaid, creating a Health Care Commission and growing our health-care workforce, we can transform our health-care system;

- Long-Term Care-Seniors represent the fastest growing population in Alaska and it is our responsibility to determine what kinds of services we want for our aging parents (and grandparents) in order to keep them at home in their own communities. We need to develop a long-term care plan, improve services to those with Alzheimer's Disease and related disorders, and promote the expansion of aging and disability resource centers;

- Vulnerable Alaskans-We need to ensure that both kids and communities are safe, that developmentally disabled kids and adults have access to quality services and supports, and that individuals and families get the kind of financial and vocational supports they need to be contributing members of society. By focusing on family-centered services and through the use of performance-based standards and funding, we can better meet the needs of our most vulnerable citizens and their families.

The Title V/CYSHCN program will work to integrate its goals into the department's to assure continuity of services and meet our performance objectives.

The Process to Determine Alaska's Title V MCH Priorities:

Alaska's FY 2010-2015 Title V Needs Assessment was completed in July 2010 by WCFH. Alaska relies on an on-going, continuous engagement with stakeholders to assess MCH needs. WCFH activities revolve around four functions: meeting with WCFH-established advisory committees; participating as a member in other organizations' committees; partnering with other agencies on program implementation; and research.

For the 2010 Needs Assessment, WCFH held a workshop on February 19, 2010. Stakeholder input was obtained by using a collaborative thinking strategy. This technique, called a World Café conversation, was used previously at DHSS in the development of the Early Childhood Comprehensive Systems Program and in WCFH's Safe Infant Sleep Initiative. One hundred seventy invitations were issued to a wide variety of stakeholders across the state; 46 individuals were able to participate.

Three powerful questions were designed to elicit collaborative thinking and deep conversations among very small (3-4) groups of people of different backgrounds and who share a common interest in maternal and child health.

The Needs Assessment Leadership Committee, composed of 10 WCFH program managers and the WCFH Section Chief, met over two months to develop priorities. The themes from the café conversation were primarily process oriented as opposed to program oriented. The Committee decided to use current priorities as a starting point. The following criteria were used to develop new priorities or reconfirm current priorities:

1. Clinical Severity - mortality, years of potential life lost, long term effects, etc.
2. Urgency - comparison to U.S. baseline, and trends
3. Disparities
4. Economic loss
5. Intervention Effectiveness
6. Capacity - within scope of WCFH; community acceptability; legality; availability of state resources
7. Encompasses the life course
8. Known to be protective
9. Identified as a risk factor in Alaska studies

In addition to the café conversation meeting, WCFH conducted SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses with the various program advisory committees supported and led by WCFH.

The Needs Assessment process will be on-going throughout the five-year cycle. The structure is in place to produce updates to the WCFH Fact Sheets that will be shared with the stakeholders from this process, state staff, and made widely available to the public/private health community. The MCH Epidemiology Unit within WCFH produces a biannual Alaska MCH Data Book that is widely distributed throughout the state.

Meetings with stakeholders is also a continuing process in the five-year cycle, with at least one meeting per year to distribute fact sheets, discuss progress on the state priorities and activities, and any current and emerging issues that may impact the state's capacity to address identified issues. Meetings with stakeholders also occur several times a year with each of the WCFH MCH programs' advisory committees.

Current and Emerging Issues

There are numerous issues in MCH that are key in developing Title V strategies, programs and initiatives. These include:

- Workforce development. There is a chronic shortage of pediatric subspecialists. Existing resources are concentrated in Anchorage. Access to these resources from outside the southcentral region entails high transportation costs.
- Chronic conditions in children. While there is no state-wide surveillance of child weight, one-third of children entering kindergarten and first grade in the Anchorage School District were overweight or at-risk for becoming overweight. Tooth decay is currently the most prevalent chronic health issue among children.
- Teen birth. While the teen birth rate of younger teens (15-17) in Alaska is slightly below the national average, the rate among older teens (18-19) is considerably higher than the national average.
- Implementing systems of care and family-centered services. The state seeks to provide an integrated set of early childhood programs through the Early Childhood Comprehensive Systems project. Title V supports this effort to connect state, federal, community, tribal and private provider services that focus on children 0 - 8 years of age.
- Substance abuse. Alaskans continue to experience high rates of substance use. These are risk factors not only for chronic conditions but also for family instability and poor birth outcomes.
- Mental health. Alaska continues to have unacceptably high rates of teen suicide. In addition, child mental health and maternal post partum depression are continuing issues of concern.
- Early intervention. Alaska is increasingly turning its focus on early intervention. Current policies that support early intervention include universal newborn metabolic screening and newborn hearing screening. Early screening for autism and other neurodevelopmental disorders is also a priority. Early intervention can significantly improve a child's outcome for school readiness and general health.
- School health. The increase of chronic conditions among school age children, such as asthma, autism, or diabetes, will require school districts to develop capacity to meet the medical needs of the children during the school day. Currently the capacity does not exist in the smaller school districts.
- Health insurance coverage for children. Approximately 11% of children in Alaska are not covered by health insurance. In 2008, legislation was passed to restore eligibility in the state's CHIP program to 175% of poverty level. Other tweaks in the Medicaid system, such as allowing expanding the approved enrollment period from 3 to 12 months, can increase coverage. The EPSDT program is an important component of the child immunization program and early intervention efforts.

Legislation

FY 2010 - 26th Legislature
In 2009. Governor Parnell put forth an initiative to end domestic violence. The 10-year plan includes a public education campaign in partnership with the Alaska Network on Domestic Violence & Sexual Assault and the Council on Domestic Violence and Sexual Assault; provide meaning law enforcement presence to every community; toughening guidelines for handling sexual assault cases; increase funding for shelters; and coordinating federal, state, tribal and non-profit programs through the Department of Law. Unfortunately, not as much emphasis was placed on primary prevention or secondary prevention, nor was money appropriated for such activities. Nevertheless, WCFH continues to partner and fund primary prevention efforts focused on health relationships and prevention of date rape/intimate partner violence. In addition, the Title V MCH block grant provides substantial funding to support state staff who work to educate health care providers about early screening, intervention efforts and the effects of violence on early brain development.

SB 221 established the framework for the Alaska Merit Scholarship program for high school graduates who are Alaska residents to attend a qualified postsecondary institution in the state. The legislation also established a commission to explore funding mechanisms.

Two important bills did not pass. SB 101 would have allowed passive parental consent for the Youth Risk Behavioral Survey. This would have significantly improved response rate. SB 13 would have increased income eligibility for the CHIP program (Denali KidCare) from 175% to 200% of federal poverty level. The bill was vetoed by the governor on grounds that the program covers abortion services. (A 1993 court order requires the state the fund abortions determined medically necessary).

***An attachment is included in this section.***

## B. Agency Capacity

Alaska's state health agency, the Department of Health and Social Services (DHSS) has significant capacity to serve women and children from prenatal care and birth through adolescence and adulthood, including health care services for CYSHCN. WCFH is the state's designated Title V agency. There are three critical issues the state faces in providing comprehensive care: geographic isolation, low population density, and shortages in workforce capacity. As mentioned in Part III A, Alaska's health care system differs from other states. There only two locally organized health departments that function under the umbrella agency of the state health department. The key factors in building capacity within the state are the collaborations and partnerships among state agencies as well as between the state and the private sector, tribal entities, the non-profit sector, local communities, other public agencies, and families. Coordination of health components and coordination of health services at the community level occurs through a mix of technical training, partnerships and direct grants to local providers.

Capacity to provide preventive and primary care services for MCH populations and
State support for communities

Community-based services are integral to a comprehensive system of preventive and primary care services for our four primary populations: that of pregnant women and infants, women across the lifespan, children and adolescents, and children/youth with special health care needs. One of the most active community-based health care systems is the Alaska Public Health Centers. The state currently supports Public Health Centers in 23 communities and offers itinerant reproductive health, disease outbreak investigaton, and immunization services to remote/frontier communities that do not have a health center. Some of the centers also offer EPSDT exams for children. The Public Health Centers are staffed by Public Health Nurses and the Division of Public Health, Section of Nursing, oversees staffing of the centers. WCFH and the Section of Nursing have long been partners in identifying and providing needed services for the MCH population. For example, family planning service including contraceptive supplies are offered a some of the Public Health Centers made possible with funding by the Title V MCH block grant. Public Health Centers and Public Health Nurses are also the state's frontline providers of initial prenatal care, immunizations, referrals for specialty care, EPSDT services, maternal health services, etc. Public Health Nursing is frequently contacted when following up with abnormal screens, and lab data. The public health nurses are also critical in some communities to help coordinate the specialty and genetics clinics held in the regional hubs.

The state offers grants to local health care providers and organizations to deliver direct services to women and children. These grants build health care capacity at a local level by supporting local expertise and health care facilities as well as supporting the economic base of small communities with jobs and career options for local populations. Direct grants to local communities are available for Infant Learning Programs, WIC, school-related initiatives, family and community nutrition, breast and cervical cancer screening outreach, reproductive health care and oral health. These locally based efforts are also important to bring culturally competent care to predominately Native communities in remote and frontier areas of the state. For example, the state supports

training and education programs, some through the University of Alaska distance delivery or on-campus programs, to educate and train paraprofessionals to deliver WIC, Infant Learning, community health aides, and professional services such as nursing, early childhood teachers and others.

Primary and preventive care to the Alaska Native population at the community level is delivered through village/sub regional clinics and regional hospitals operated by regional non-profit tribal health corporations under the Alaska Native Tribal Health Consortium (ANTHC) umbrella. Individuals qualified to receive services at ANTHC facilities may also choose to use private sector resources. The state assists regional health corporations by collaborating on grants and providing expertise, education and training.

Collaboration with other agencies and organizations

The state's capacity to deliver services to the MCH and CYSCHN populations has been built on the foundation of strong partnerships and collaboration among state agencies, federal programs, the tribal health care system, the private sector, and community-based organizations.

Creating multi-agency advisory committees is one way of establishing and maintaining collaborations. For example, WCFH maintains strong relationships with medical providers and other health care professionals through the NBMS (Newborn Metabolic Screening) Advisory Committee. Issues considered by the committee in the past included hemoglobinapathies, adding cystic fibrosis screening to the screening panel, and implementing tandem mass spectrometry. A sub task force met to improve the mail out and delivery times of the screening cards that are sent from the various birthing hospitals to the state public health lab in Portland, Oregon.

Another excellent example of using partnerships to expand agency capacity is the major role played by the Newborn Hearing Screening Advisory Committee. The Committee initiated the newborn hearing screening program statewide, organized advocates in a six year effort to successfully pass mandatory hearing screening legislation in 2006, and continues to provide input in service delivery and program sustainability, and improving early intervention and treatment options. Capacity has been expanded through partnership with hospitals, birthing centers, and private providers to ensure implementation of the program including follow-up diagnostics and treatment for children who do not pass the initial screens. This newborn screening initiative has been an important and successful partnership between the state, local hospitals, specialty providers and advocacy organizations to provide a comprehensive system of care for children with hearing impairments.

Program management and operations affecting MCH and CYSCHN populations are spread among multiple state agencies in Alaska. An example of interagency collaboration to expand capacity was the effort between the directors of the Division of Health Care Services and the Division of Public Health. They worked collaboratively on issues such as transportation to medical appointments for children (a big expense in the Medicaid budget due to lack of access in many rural villages); recruitment of sub specialists to meet the needs of children who are Medicaid beneficiaries and who require specialized care not available in the state; and a quality improvement project on timely discharge for medically fragile children from the Level II and III NICU. These collaborative efforts have greatly enhanced the capacity to meet the needs of children with special health care needs. This last effort also included staff from the Sections of Licensing as well as the Division of Senior and Disability Services, hospital case managers, and private care coordinators.

Successful interagency collaboration has also been key to implementing comprehensive, integrated systems of care. In 2008 an Early Childhood Mental Health (ECMH) cross-systems working group, including the Title V MCH Director, was formed to develop recommendations on mental health services. One of the outcomes was the crosswalk between diagnostic codes for

young children, billing requirements, and the use of appropriate service codes to ensure services for young children. This resulted in adoption by regulation of the DSM-III diagnostic codes to support childhood mental health services for payment in the Medicaid system. In addition, the collaboration with Early Comprehensive Care Systems Grant (ECCS) led to piloting a system of developmental screening as part of the ABCD Screening Academy project. Efforts are underway with the Medicaid agency to require in regulation the use of one of two evidence-based developmental screening tools as part of a well child screening evaluation. Work is also in progress in with the Division of Behavioral Health, the Office of Children's Services and the University of Alaska to develop early behavioral health intervention training and curriculum and programs in collaboration with the Early Intervention/Infant Learning programs.

These summarize WCFH's ongoing relationships with state health agencies:

- Title V programs including Adolescent Health, Women's Health, Perinatal Health, School Nursing Consultation and School Health, Breast and Cervical Health Check, Oral Health, Newborn Metabolic Screening, Early Hearing and Detection Screening, Title X Family Planning, Genetics and Metabolic Clinics, Cleft Lip and Palate Clinic, Neurodevelopmental Outreach and Autism Screening Clinic, Family Support Services and the MCH Epidemiology programs are housed within WCFH under the supervision of the Title V Director. The MCH-Epidemiology Unit manages six surveillance programs that provide data for program design and evaluation, research efforts, grant applications, and policy guidance.
- Medical Examiner's Office - provides information for the Maternal Infant Mortality Review/Child Death Review.
- Section of Chronic Disease and Prevention -- WCFH/MCH- Epidemiology Unit provides primary data on nutrition and weight, collected through the PRAMS and CUBS surveillance programs, for the Obesity Prevention and Physical Activity Program.
- Bureau of Vital Statistics (BVS) - the WCFH/MCH-Epidemiology Unit has data sharing agreements with BVS that allows the epidemiology staff to link surveillance and Medicaid data for research and analysis.
- Section of Public Health Nursing -- Family Nurse Pracitioner salary support, contraceptives and cervical cancer screening services purchased with MCH Titel V block grant funds support reproductive health services provided by Section of Nursing at the Public Health Centers. Public Health Nursing is frequently contacted when following up with abnormal screens for children identified through the EHDI or NBMS programs. Public health nurses act as case coordinators for families using the neurodevelopmental, autism outreach, genetics and metabolic clinics.

WCFH's ongoing relationships with other state agencies include:

- Division of Health Care Services (CHIP program) - WCFH collaborates with Medicaid/CHIP to expand coverage of vital services for CYSCHN such as payments of OT, PT, Speech-Language and Audiology services to schools that enrolled as providers of Medicaid. WCFH also collaborate on EPSDT outreach.
- Office of Children's Services - WCFH participates on the steering committee of the Early Childhood Comprehensive System (ECCS) program and also assists in the implementation and evaluation of the ECCS program. Title V block grant funds are used to support child abuse and neglect prevention efforts. Funds from the HRSA UNHS grant support education for early intervention/infant learning providers in rural parts of the state.
- Division of Public Assistance - MCH-Epidemiology Unit uses WIC data to research child outcomes for anemia and h. pylori infection. PRAMS data is supplied to WIC for program guidance. WCFH partners with DPA to combine TANF and Title V funds for reproductive health services in regions of high teen birth rates and high non-marital birth rates. TANF funds are also utilized in healthy relationships education and prevention of intimate partner violence.
- Division of Juvenile Justice (DJJ)- WCFH is working closely with DJJ to link data for the child maltreatment surveillance system, managed by MCH-Epidemiology Unit.
- Intra-agency committees - The Title V Director is a member of several intra-agency, director level committees responsible for health policy. These include:
  - Strengthening Families (SF) Leadership Team. The team, focused on strategies to

reduce child abuse and neglect, continues to work towards embedding this framework in state policies and systems.

o The Children's Policy Team, led by the DHSS Commissioner. The team convenes semi-monthly with senior division executives and their staff to report on a number of children's issues and plans for resolution. Standing agenda items include behavioral health improvements in-state for adolescents, particularly in the area of residential treatment centers, progress on autism initiatives, early mental health services for children ages 0-8, and development of systems of care models with a goal towards collaboration among all the divisions having responsibilities for child outcomes.

o The Early Childhood Comprehensive Systems (ECCS) Steering Committee. The Title V Director, the epidemiologist for MCH Indicators (from the MCH-Epidemiology Unit) and the Family Services managers are active participants on the implementation committees. The Title V Director represents the Division of Public Health on the interdepartmental ECCS committee chaired by the Commissioner of the Department.

Regional collaborations have also been useful. The Title V/CYSHCN director, newborn screening coordinator, and genetic counselor participated in the implementation of the Western States Genetic Services Collaborative, a regional project focused on expansion of genetics services, education and collaboration among states. The collaborative is working on standardization of data collection to achieve comparability of data across states.

WCFH collaborates with entities within the Alaska Native Tribal Health Consortium (ANTHC) in numerous venues such as co-sponsorship of conferences, assisting with development of grant applications by regional tribal health non-profit agencies, sharing research and data with the Native EpiCenter, and having tribal involvement on WCFH program advisory committees.

WCFH collaborates with other public and private organizations in the following manner:

- WCFH staff works with providers from Seattle Children's Hospital and Medical Center, funded by MCH Title V grants, to hold genetics and metabolic specialty clinics around the state.
- WCFH invites coalitions and non-profit agencies to participate in advisory committees and stakeholder meetings such as the March of Dimes, Planned Parenthood, the Association of Women's Health, Obstetric and Neonatal Nursing, American Academy of Pediatrics-Alaska chapter, Stone Soup Group, , YWCA, and families who participate in Title V programs.
- WCFH has a strong relationship with the University of Alaska-Anchorage (UAA) and the University of Alaska-Fairbanks. WCFH staff members are frequent lecturers in the dental hygiene, human services, nursing, child development, laboratory science and MPH programs. The Title V director serves on the advisory program for the UAA's MPH program. The University Affiliated Program at UAA is a close collaborator in developing programs for CYSHCN, especially in the area of transition from adolescents to adulthood. The Title V director is also on the University of Alaska Anchorage committee to develop a doctorate of nursing practice program.
- The Title V/CYSHCN Director and the Children's Health Unit Manager are active participants in the All Alaska Pediatric Partnership, a community coalition of hospitals and medical providers serving the pediatric population of the state.
- The Title V/CYSHCN Director was active in Project Access, a program available in Anchorage for individuals who are underinsured or have no insurance.
- Title V providing funding assistance for post partum depression screening at the Children's Hospital at Providence Hospital.
- WCFH collaborates with the Primary Care Association, a private non-profit organization representing primary care providers , to promote the use of medical homes and expand children's care reproductive health services.

State statutes relevant to Title V authority, and impacts upon the Title V program

As of January 2008, Alaska law mandates universal newborn hearing screening for all babies born in Alaska. Currently, Alaska's screening rate for hospital births is about 98% and screening

is now performed at all birthing hospitals. Several strategies have been employed to increase screening rates and quality of data including purchase of portable hearing screeners for the smaller communities, disseminating culturally appropriate public education to the general public, providing technical training to direct-entry midwives and Community Health Aide/Practitioners (CHA/Ps - rural Alaskan healthcare providers). An important element of the EHDI program was the acquisition of software for online data input, tracking and follow-up activities, and QA reporting. Data integration with other programs such as NBMS has already been implemented. This will improve the ability to track services offered by MCH programs to all newborns. Potential linkages with other reporting systems include the immunization registry and the Early Intervention/Infant Learning Program.

Also mandated for all newborns are screening tests for PKU and other metabolic disorders that can result in mental retardation and/or other serious health problems. Alaska currently screens for 11 categories (49 disorders) of metabolic and other disorders. Infants and children with positive test results are seen at Title V funded Metabolic and Genetics Clinics for treatment management and genetic counseling. Staffing for the Metabolic Clinic includes a metabolic geneticist specialist, a nutritionist and a genetic counselor. Medical consultation is provided to the local physician caring for the infant or child. The Newborn Screening Advisory Committee, composed of local physicians, laboratory personnel, family members of affected children, midwives and nurse practitioners, provides recommendations for program planning and evaluation.

AS 18.23.010-18.23.070 established the Alaska Maternal Infant Mortality Review (AMIMR) as a medical review organization to retroactively evaluate the circumstances surrounding infant death and make recommendations for reducing Alaska's high infant mortality rate. The AMIMR scope has also been expanded to review fetal and maternal deaths as well. this program has been a major contributor to the dramatic decline of infant mortality during the 1990s. The website link is http://www.epi.alaska.gov/mchepi/mimr/default.stm

The Alaska Mental Health Trust was established by the Alaska Mental Health Enabling Act of 1956 during Alaska's transition to statehood. The objective was to transfer mental health services from the federal government to the state. Funding would be provided by prudent management of one million acres of land selected by the state from federal lands. Today, the Trust has established five focus areas for its Comprehensive Integrated Mental Health Program. Recently, the Title V Director collaborated with their "Bring the Kids Home" initiative to provide more in-state residential behavioral health treatment facilities so that adolescents can remain in Alaska for long term treatment. Trust funds are combined with Title V funds for specific programs such as parent navigation services. The Trust's website is http://www.mhtrust.org/index.cfm?section=about-us&page=About-The-Trust

There are a variety of statutes regarding mandatory reporting of health related issues. These include:

- AS 08.64.369 requires health care professionals to report 5 categories of injuries to the Department of Public Safety (DPS):
(1) second or third degree burns to five percent or more of a patient's body;
(2) a burn to a patient's upper respiratory tract or laryngeal edema due to the inhalation of super-heated air;
(3) a bullet wound, powder burn, or other injury apparently caused by the discharge of a firearm;
(4) an injury apparently caused by a knife, axe, or other sharp or pointed instrument, unless the injury was clearly accidental; and
(5) an injury that is likely to cause the death of the patient, unless the injury was clearly accidental.

- AS 47.17 requires 7 categories of professionals to immediately report information to the Office of Children's Services if they have reasonable cause to suspect a child has suffered harm

as a result of abuse or neglect. The categories include health practitioners, administrative officers in institutions, employees of domestic violence and sexual assault programs, employees of counseling organizations, law enforcement officers and child care providers.

- 7 AAC 27.012 Physicians, hospitals, and other health care facilities and providers must report children from birth up to 6 years of age who have been diagnosed with or treated for a specific list of birth defects.

- Other health conditions including specific infectious diseases, sexually transmitted diseases, elevated blood lead, cancer, firearm injuries, and diseases caused by toxic substances are also required to be reported. A full list of reportable conditions can be found at http://www.epi.hss.state.ak.us/pubs/conditions/crWhat.htm#birthPhysicians.

In 2007 the state legislature increased the CHIP income eligibility to 175% of poverty level. Inflation had reduced to the eligibility to 150% of poverty level in prior years. The 26th Legislature (2009-2010) passed legislation to increase income eligibility to 200% of poverty level, but the bill was vetoed by the Governor on grounds that the program could cover abortions.

Services for CYSHCN

The inability to access specialty care poses significant hardships for CYSHCN. To address these challenges, a coalition of state and private agencies developed a broader definition of a medical home for Alaska CYSHCN: "The medical home is where a child with special health care needs and his or her family can count on having medical care coordinated by a health care professional they trust. It is not a building, house or hospital, but rather an approach to providing quality and coordinated services". Itinerant public health nurses visit most of Alaska's rural communities providing the "medical home" for many of Alaska's children and families. An R.N., Nurse Practitioner, Community Health Aide or Physician's Assistant provides primary and preventive care in many cases. Primary health care providers and families work as partners to identify and access all of the medical and non-medical services needed to help CYSHCN achieve their potential. Working from this base, a coalition of providers are currently engaged in building a base of specialists and sub-specialists in children's health, holding specialty clinics in rural communities, coordinating specialty care with families either on an itinerant basis or helping families access services in larger communities. As the FQHCs and community health centers before more firmly established, the Title V and CYSHCN staff is working with them on developing greater competency and capacity to care for CYSHCN, adolescents and prenatal women.

Specialty clinics are sponsored throughout the state since these services are not available locally. Multidisciplinary evaluations are conducted at Cleft Lip and Palate (CL/P) Clinics in Anchorage, Bethel and Fairbanks. Children receive consultations at the Autism and Neurodevelopment Clinics in Nome, Kotzebue, Soldotna, Valdez, Barrow, Dillingham, Fairbanks, Juneau and Ketchikan and consultations at Neurology Clinics in Fairbanks. Parent navigation services are offered to assist families to initiate treatment plans, find funding for underinsured or uninsured clients and navigate the health care systems as needed. The paraprofessional navigators are funded through a grant with the Stone Soup Group using Title V funds, general funds, and mental health funds. Parent navigator services are gradually being extended to families with other special needs conditions such as newborn hearing loss, genetics and metabolic conditions. A pilot is being considered with Medicaid services to offer parent navigation for families who have children with chronic health conditions such as diabetes, cancer and asthma in coordination using a nursing case management. The state works closely with The Children's Hospital, Providence Hospital Neurodevelopmental/Autism Center, with referrals to the multidisciplinary team for diagnostic evaluations through the Providence Autism Diagnostic Network. Funding support is provided by the WCFH/Title V agency through a grant using general funds and mental health funds.

Since 2004, the staff of the Division of Health Care Services and the Division of Public

Health/WCFH have worked collaboratively on projects to expand capacity such as transportation to medical appointments for children (a big expense in the Medicaid budget due to lack of access in many rural villages); recruitment of subspecialists to meet the needs of children who are Medicaid beneficiaries and who require specialized care not available in the state; and a quality improvement project on timely discharge for medically fragile children from the Level II and III NICU. These collaborative efforts have greatly enhanced the capacity to meet the needs of children with special health care needs. This last effort also included staff from the Sections of Licensing as well as the Division of Senior and Disability Services, hospital case managers, and private care coordinators.

In 2008 an Early Childhood Mental Health (ECMH) working group, including the Title V MCH Director, was formed to develop recommendations on mental health services for young children. One outcome was a crosswalk between diagnostic codes for young children (DSM-III), billing requirements, and the use of appropriate service codes to ensure services for young children. That work was helpful in the development of an Early Comprehensive Care Systems Grant (ECCS) and the collaboration around a pilot program for continuous developmental screening as part of the ABCD Screening Academy project. Work is in progress with the Division of Behavioral Health, the Office of Children's Services and the University of Alaska to develop early behavioral health intervention training and curricula for the Early Intervention/Infant Learning program.

Ongoing support for the EPSDT program resulted in an expansion of services and payments of OT, PT, Speech-Language and Audiology services to schools that enrolled as providers of Medicaid. Nearly 50% of the children in Alaska are enrolled in the Medicaid program and many have special needs. Enhancing the payment methodology for schools will hopefully provide for increased funding to hire additional needed specialists and provide services for children who qualify for an Individual Education Plan (IEP).

Continuing objectives for the Newborn Metabolic Screening Program are to maintain quality of specimen collection and to reduce hospital discharge refusals. Objectives for the Early Hearing Detection and Intervention are to improve data collection, reduce refusal rates, and increase participation among non-hospital births. These objectives are pursued through targeted educational efforts, training, building strong relationships with providers, and continuous tracking and follow-up. Major efforts were made to implement database linkages between these two programs and with the Early Intervention/Infant Learning Program in order to provide service integration.

In FY2009 the MCH Title V/CYSHCN director was successful in obtaining general funds to provide ongoing support to the Alaska Birth Defects/FASD registry. That program had been entirely funded during the previous four years by the MCH Title V Block grant. In addition, the program now receives over $500,000 in general fund/mental health dollars to support capacity building and expand early identification for children experiencing autism and neurodevelopmental conditions. The new funding source will help assure long term sustainability for programs and system development in support of CYSHCN.

Examples of culturally competent approaches

Applied research conducted by the MCH Epidemiology Unit includes data stratification by Alaska Native status. For example, an analysis of birth certificate data identified 3 new risk factors associated with elevated risk of postneonatal mortality among Alaska Native population. Analysis of the Alaska Birth Defects Registry showed that Alaska Native infants have higher rates, compared to non-Native infants, for 10 of the 15 most commonly identified major congenital anomalies. Collection and analysis of data related to specific congenital anomalies recently led to collaboration with Washington University in Missouri researchers to investigate risk factors for Hirschsprung's Disease. MCH Epidemiology Unit collaborated with CDC and Alaska Native health organizations on a randomized clinical trial to determine the contribution of Helicobacter pylori (Hp) infection to iron deficiency and anemia (prevalence among Alaska Native children and

pregnant women are 10-fold higher than other US populations). The results of this study had a direct impact on clinical practice. The Unit is also collaborating with ANTHC's EpiCenter on an Alaska Native health status data book, publication is expected by the end of 2010.

The Youth Alliance for a Healthier Alaska team (YAHA), composed of teens ages 16-19, was formed in 2009 to assist the Adolescent Health program manager design prevention programs around teen pregnancy, healthy relationship promotion and dating violence prevention. A teen summit held in May 2010 included participation of 26 at-risk youths. The input will be used to tailor intervention programs to the culture and attitudes of the local community.

CPT1 (carnitine palmitoyl transferase-1), a condition included in the newborn metabolic screening program, is a metabolic deficiency that occurs more frequently in certain indigenous populations of Alaska and Canada. WCFH created a CD explaining the condition and what parents should do specifically for Alaska Native parents.
http://www.hss.state.ak.us/dph/wcfh/metabolic/downloads/cpt1_brochure.pdf) The Infant Safe Sleep Initiative will be developing culturally appropriate social marketing messages on reducing risks in infant sleep environments. Brochures for the newborn hearing program and the breast and cervical health check programs are targeted to diverse populations.

Two staff members will be receiving MCH /HRSA technical assistance funding for cultural competency work at the statewide MCH Immunization Conference post session in Fall 2010.

## C. Organizational Structure

Organizational charts for the Alaska Department of Health and Social Services (DHSS), the Division of Public Health, the Section of Women's, Children's and Family Health, and the Office of Children's Services can be found under Other Supporting Documents. The WCFH Organizational Chart includes positions by program as well as job classification.

Alaska's state health agency, DHSS, is one of 15 departments comprising the Executive Branch of Alaska's state government. The Governor directs the activities of each of these departments through appointed cabinet level commissioners. The DHSS organizational structure is broken down into Divisions with an appointed director to oversee all activities for their Division. The Division of Public Health within the DHSS is charged with primary responsibility for MCH programs. However, two significant programs reside in the Office of Children's Services (Early Intervention/Infant Learning Program) and the Division of Public Assistance (WIC). An organizational chart for the Department is attached.

Alaska differs from most states in that it does not have county health departments that function under the administrative arm of the state health agency. Alaska's health care system is a mix of direct state services, regional and local tribal health care agencies, and private practice health care providers. The state operates local public health centers in 23 communities and offers itinerant public health nursing services for those communities not served by public health centers. The Municipality of Anchorage and the North Slope Borough are the only communities that have locally organized health departments. Federally funded hospitals provide health care services to Alaska's military and Native populations. Additionally, health care services are provided to the Alaska Native population through regional and village health clinics operated Alaska Native Tribal Health Consortium. Other services for MCH populations are provided by non-profit agencies using grant funds from state, federal or other non-governmental funding sources. The state, then, can be involved in providing health care services on numerous levels, as a direct service provider, through grants, or as a partner with Native, federal and private health care organizations in the planning, provision and coordination of health care services.

Currently, the responsibility for some of the state's MCH Title V programs, and the position of

Title V and CYSHCN Director, reside in the Division of Public Health. Decisions regarding funding allocations for the Title V grant will be made by the MCH Title V Director with input from the Director of the Division of Public Health and approval from the DHSS Commissioner.

For those programs funded by the Federal-State Block Grant Partnership, the state's administrative role is as follows:

1. Early Intervention/Infant Learning program. This program is located in the Office of Children's Services. The state general funds spent on this program provide a large portion of the state match of the Block Grant and portion of the Federal-State Partnership. While DHSS is the umbrella organization for both the Title V administrative organization (i.e. the Division of Public Health) and the Office of Children's Services, there will continue to be a coordinated effort to provide information required for the Block Grant application both programmatically as well as fiscally.

2. Women, Infants and Children (WIC) Nutrition program. This program is located in the Division of Public Assistance. There are some state funds that support this program in the form of team nutrition grants, however the bulk of funding comes from the USDA. The WIC program and the other former MCH programs continue to collaborate on activities and participate jointly on statewide committees.

3. MCH surveillance activities. These activities are located in DPH, Section of Women's Children's and Family Health (WCFH).

4. Family Violence Prevention and Childhood Injury Prevention are located in DPH, Section of Chronic Disease Prevention and Health Promotion.

5. Children's Behavioral Health is located in the Division of Behavioral Health.

6. Family Nutrition, the Early Comprehensive Care Systems (ECCS) grant, the Early Intervention Program and the Healthy Families Home Visitation program are located in the Office of Children's Services. The Title V Director and some WCFH staff actively participate in work conducted with the ECCS and Early Intervention program.

7. Primary MCH programs are located in DPH Section of WCFH These include Newborn Metabolic Screening, Newborn Hearing Screening (EHDI), Specialty Clinics, Birth Defects and Genetics Clinics, Neurodevelopmental/Autism Outreach clinic, Oral Health for Children and Adults, Family Planning, Abstinence Grant administration, Adolescent Health, School Health, and the Breast and Cervical Cancer program and Perinatal and Women's Health.

The strengthening of interagency working relationships to support MCH programs has been a priority over the last five years.

***An attachment is included in this section.***

## D. Other MCH Capacity

Maternal Child Health programs are currently implemented by four divisions within the Department of Health and Social Services: the Division of Public Health, the Office of Children's Services, the Division of Public Assistance, and the Division of Health Care Services. Some of these programs were formerly within the Division of Public Health, however, a major departmental reorganization in 2003 shifted several programs and Title V oversight to other existing or new divisions. In 2005, another smaller scale but significant reorganization returned several MCH programs to a new section (Women's, Children's and Family Health) within the Division of Public Health. From 2003 to 2006 a significant number of positions were eliminated, left vacant,

changed position descriptions or experienced turnover.
Division of Public Health-Section of Women's, Children's and Family Health (49 positions):

- Section Chief (Title V/CYSHCN Director) - 1 position.
- MCH Epidemiology Unit:
  - Administrative Support - 1 position;
  - PRAMS -- 2.5 positions;
  - Alaska Birth Defects Registry (ABDR) and FAS Surveillance Project -- 3 positions;
  - Pediatric Physician Epidemiologist - 1 position;
  - Maternal-Infant Mortality Review/Child Death Review Committee -- 1 position;
  - MCH Indicators Surveillance position - 1 position;
  - MCH Epidemiologist - 1 position;
  - Surveillance of Children who experience Abuse and Neglect -- 1 position;
  - Toddler Survey (CUBS)- 2.5 position;
  - Public Health Specialist -- 1 position (vacant)
  - MCH/HRSA Intern-1.0 position (not counted in Total)

- Women's and Adolescent Health Unit:
  - Administrative Support - 1 position;
  - Breast and Cervical Cancer Screening program -- 7.0 positions;
  - Family Planning -- 1.25 positions;
  - Perinatal Health -- 2.0 position (0.75 Vacant)
  - Reproductive Health Partnership --0.75 position
  - Adolescent Health- 2.0 position (1.0 Vacant);
  - School Nursing Consultation and School Health 1.0 position
  - MCH Disaster Planning-0.25 (Vacant)
  - MCH/HRSA Intern -1.0 position (not counted in total)
- Children's Health Unit:
  - Administrative Support -- 3.0 positions
  - Newborn Hearing Screening -- 1.5 positions
  - Newborn Metabolic Screening -- 1.5 positions
  - Genetics and Birth Defects Program -- 1.5 positions (one is contracted)
  - Autism: 1.25 positions
  - Pediatric Specialty Clinics and Family Support Services -- .75 positions
  - Oral Health - 3.0 positions (1 in Juneau and 2.0 in Anchorage)
- Section Administrative Support:
  - Administrative Assistant II: 1 position
  - Office Assistant III: 1 position
  - Office Assistant I: 1 positions
  - Accounting Clerk: 1 position

Section of Chronic Disease and Prevention:

- Alaska Family Violence Project - 2 positions (financial Support provided by MCH Title V Block grant)
- Child Injury Program - 1 position.

Office of Children's Services:

- Early Childhood Comprehensive Systems Program - 1 position (financial support provided by MCH Title V Block Grant)
- Early Intervention/Infant Learning Program: 4 positions.

Division of Health Care Services

- EPSDT program - 1.5 (1.0 Vacant)

Division of Behavioral Health:

- Suicide prevention support - .5 positions.

Division of Public Assistance:

- Prevention Services
  - Unit Manager - 1 position
  - Administrative Support - 2 positions
  - Community and Family Nutrition Services - 1 position
  - WIC Nutrition Programs - 10 positions in Anchorage and Juneau

All information technology positions (analyst programmers, web masters, etc.) are centralized under the Division of Finance and Management Services, led by the Assistant Commissioner of DHSS.

WCFH staff members are well qualified to deliver services required by Title V MCH, children with special health care needs, and other grant and special funding streams. Over 16 staff members have a master's in public health and four others have master's degree in administration, education, biostatics, planning or other related fields. Seven staff members have double master's degrees. There are also several health care professionals on staff including a pediatrician, a family nurse practitioner, 4 registered nurses, a medical social worker, a MCH registered dietician, a dentist and a dental hygienist.

The Title V MCH/CSHCN Director, Stephanie Birch, has a double master's degree in maternal child public health and nursing with a concentration as a family nurse practitioner. Prior to joining the Division of Public Health, she worked as a registered staff nurse and clinical director. She was the developer and administrator of the state's only children's hospital. Ms. Birch continues to practice in a community-based nurse practitioner practice that serves a low income neighborhood in Anchorage.

The Deputy section chief, Thalia Wood, has a master's in maternal and child public health. Her additional part time as a lab supervisor complements her work as manager of the Newborn Metabolic Screening program.

The Family Support Services manager, Kristine Green, in particular came with first- hand experience having delivered premature twins several years ago. Since that time she has spent 18 years working with parents of children with special health care needs, tobacco cessation programs and behavioral health support services. Prior to her hire with WCFH, she developed parent navigation and care coordinator services at The Children's Hospital at Providence, a postpartum support program and several specialized support programs for families with children experiencing chronic illnesses, such as cancer, cystic fibrosis and juvenile diabetes. She works closely with the Family Voices representative on family leadership development and is assisting to develop a Family Advisory committee for the Title V program.

Dr. Brad Gessner, our staff medical epidemiologist and lead research consultant, is a pediatrician who practices part time at the Anchorage Neighborhood Health Center, a community-based facility serving low income clients. He is also is employed by the Pasteur Institute evaluating vaccination programs. Dr. Gessner's combined experience in clinical practice and research has been extremely useful in designing studies with real-world implications. His research on Alaska MCH issues has been extensively published in peer-reviewed journals. The public health specialists in the MCH Epidemiology Unit have master's degrees in public health with concentrations in biostatistics, epidemiology, and evaluation. A list of publications by the MCH-Epidemiology Unit is attached.

The WCFH program staff has impressively diverse experiences including Peace Corps, Vista, public health nursing in rural Alaska, public health internships in third world countries, community planning, early intervention programs, parent navigation and family service delivery in the tertiary hospital, disability service delivery, laboratory supervision, school nursing, genetic counseling and community health education. Ongoing training plans are a part of the annual evaluation process and staff are encouraged and supported to gain new skills and try new programs as opportunities

present themselves. All staff members regardless of their position or degree are offered training stipends for public health conferences or education related to their program.

The current WCFH budget is comprised of 60% federal dollars, 15% receipt support services (fees collected at clinics or for newborn metabolic screening), 25% general fund or specialized general fund dollars. Funding for WCFH has increased steadily every year, particularly in the area of general fund/mental health dollars designated to expand neurodevelopmental screening, and early autism screening and diagnostic expansion. It is not anticipated that WCFH or the Division of Public Health will experience cuts in spending, however , sections and programs may experience reductions over time as funding becomes stagnant and levels do not support required salary increases or additional costs for infrastructure. As new federal grants opportunities are released, WCFH has been supported to date in submitting applications. The challenge will be in obtaining additional FTE's to support grant requirements in light of a mandate from the current administration that no new positions will be approved.

## E. State Agency Coordination

WCFH is grounded in the philosophy that strong partnerships and a collaborative approach are critical for systems development, implementation, service delivery and, ultimately, achieving the mission of the Section. A reorganization of DHSS in 2003 created many changes for the Title V program administration, patterns of work, and relationships with other divisions within DHSS. A significant amount of effort in the ensuing years was devoted to making the organizational transition, orienting and training new staff, and maintaining services while coping with the new environment. These efforts have paid off in strengthened collaborations, new partnerships, and program efficiencies. Many of the MCH programs and initiatives are multi-agency collaborative efforts

The Children's Policy Team was formed in March 2004 to address children's behavioral health, social service and financing issues that impact several divisions or agencies within DHSS -- ultimately to better serve Alaska's children and families. The department recognizes program and budgetary overlaps. Several divisions within the department often work with the same families on social services issues in different capacities. The objective of the Child's Policy Team is to continually streamline problem-solving processes and project development on issues about children's service delivery. One objective is to collaborate with families to limit the number of state offices and state agency staff that families need to interact with in order to get their needs met. The Team began as a core leadership group within the Deputy Commissioner of Operations' office, that included the Divisions of Behavioral Health, Juvenile Justice and the Office of Children's Services (child protection). It has since expanded department wide and includes select program staff including the Title V director.

A description of partnerships between WCFH and other state agencies with MCH program responsibilities, tribal entities, and other private or non-profit agencies was given in Chapter III B, Agency Capacity.

Below is a recap of relevant organizational relationships, summarized by programs and initiatives:

Office of Children's Services (OCS). This is the state's child welfare agency.

- Early Intervention/Infant Learning program MCH Title V partners with the Early Intervention program to assure children identified with neurodevelopmental delays and disorders are referred for services. Program leaders serve on the steering committees for the autism program and the early hearing detection program. Funding is provided to the Early Intervention program from grants to support similar objectives related to early identification and treatment. WCFH staff also work collaboratively with the Early Intervention program on training for their field grantees. Early Intervention staff are encouraged to attend specialty clinic appointments of their clients when they are offered in home communities. Finally, parent navigators hired by the state

through a grant with the Stone Soup grantee link with early intervention staff when IFSP's are created and assist families in the navigation of service systems as needed.

- Early Comprehensive Childhood Systems (ECCS) program. The ECCS plan was adopted the by the Children's Policy Team and endorsed by the Commissioner of the Department of Education and Early Development. Title V staff work closely with the ECCS coordinator to implement plan objectives, specifically: to expand developmental screening, to develop a model of care coordination to ensure children with developmental or medical needs will be referred to appropriate services, and to increase the number of eligible children enrolled in a public health insurance program. Website: http://www.hss.state.ak.us/ocs/ECCS/ProgramInfo.htm
- ABCD (Assuring Better Child Development) Screening Academy - WCFH staff participated in the technical assistance provided by a grant and used the knowledge gained from that experience to work with the Medicaid EPSDT program to begin developing policies and practice for comprehensive developmental screening in medical homes during well child visits using evidence-based tools. Training on utilizing these tools for developmental screening in underway with tribal community health aides/providers (CHA/Ps) as part of the Combating Autism work. Regulation changes in the Medicaid program will likely need to occur in the near future.
- Strengthening Families Initiative - this is a multi-agency collaborative effort to expand the model across the state. Participation includes WCFH, representing the Division of Public Health, the Division of Public Assistance child care licensing, OCS, private childcare resource and referral centers, and early intervention programs. Funding for Strengthening Families is provided through the Title V MCH Block Grant. Website: http://hss.state.ak.us/ocs/families/default.htm

Division of Senior and Disability Services (DSDS):

- WCFH and DSDS collaborate on issues regarding medically fragile children such as improving coordinated care for medically fragile children discharged from the state's two main NICU's, and finding medical foster homes in a reasonable amount of time for NICU-discharged infants. A steering committee consisting of staff from the Section of Licensing, Office of Children's Services, Medicaid, NICU nurse managers, Durable Medical Equipment providers (DME), early intervention program and others participated in these quality improvement processes. The process to fulfill application requirements for the Medicaid waiver program was streamlined. This allowed a faster turnaround with discharges from the NICU. Availability of trained medical foster care continues to be an issue.

Division of Juvenile Justice:

- Improving mandatory reporting for statutory rape (referred in state statutes as sexual abuse of a minor I-IV) - WCFH led a collaborative effort with Division of Public Assistance, OCS, and Health Care Services (Medicaid) to provide training developed in part by the WCFH Women's and Adolescent Health units. The training is offered on a semi-regular basis to public health nursing centers and private providers. The Adolescent Health program works closely with the Alaska Parent and Youth Foundation and its "Proud Choices" program which is offered in juvenile detention centers in south central Alaska. This evidence-based curriculum is focused on healthy relationship development and teen pregnancy prevention. Future funding has been applied for with the hope of expanding the number of locations that this curriculum is offered.

Division of Behavioral Health:

- WCFH staff has participated in a Comprehensive Mental Health Systems committee to develop strategies to meet the goal of "bringing the children home" from outside behavioral health treatment facilities. Although the focus on prevention of behavioral health issues in very young children is not present currently, this effort has allowed WCFH staff to have an opportunity to insert information regarding the importance of early diagnosis and intervention during the very yearly years as a means to perhaps prevent a need for intervention in the teen years.
- WCFH staff participated in a workgroup to cross walk the DSM-III behavioral health diagnostic codes geared toward young children with current DSM-IV codes to assist behavioral health specialists in the community who have billing privileges with the Medicaid program.
- Behavior Health staff actively serve on the Autism steering committee. Many of the

children in residential treatment outside the state have autism as a co-morbidity and this complicates their ability to return home. Future program efforts will be focused on children with autism who are in transition and/or have significant behavioral health needs.

- The Adolescent Health program works closely with Behavioral Health staff in teen suicide prevention emphasizing the use of the Assets Model as a part of the healthy relationships work and teen leadership development.
- The Alaska Birth Defects and Fetal Alcohol Surveillance program, managed by the MCH Epidemiology Unit within WCFH, provides data analysis and evaluation to the Division's Fetal Alcohol prevention program on the effectiveness of prevention efforts.
  - Article: "Decline in the Birth Prevalence of Fetal Alcohol Syndrome in Alaska". 2/17/2010. http://www.epi.alaska.gov/bulletins/docs/b2010_03.pdf

Division of Public Assistance (DPA):

- TANF funding from DPA is the primary source of support for the WCFH Adolescent Health program. This close partnership has resulted in an expansion of contraceptive and reproductive health training and services offered to regions in the state with the highest rates of teen and out of wedlock pregnancy. The teen pregnancy prevention curriculum, focused on healthy relationship development and pregnancy prevention strategies, is offered in many schools across the state and teen leadership development is supported in many rural communities.
- WCFH staff works with the WIC program in promoting folic acid as a neural tube defect prevention strategy. WCFH recently collaborated on a departmental policy to support breast feeding for state employees.

Federally qualified health centers (FQHC):

- WCFH provides technical assistance on contraception, immunizations, and care standards for prenatal, neonatal and pediatric patients when called upon. State staff will be working this next year to make themselves more available for technical assistance in these areas..
- The Reproductive Health Partnership, a collaboration between WCFH, DPA, and tribal health corporations, provides training for reproductive health services as well as contraceptive supplies to the community health centers. This work is focused in the three areas of the state where the rate of teen and ‘out of wedlock' pregnancy are the highest

Division of Public Health: WCFH is a section within the Division of Public Health (DPH). WCFH has daily contact and close working relationships with other sections within DPH including Public Health Nursing, Chronic Disease Prevention & Health Promotion, Epidemiology, the Medical Examiner's Office and the Bureau of Vital Statistics. Each of these sections has supported MCH through data collection and analysis, providing direct health care services, and extending prevention and treatment services for MCH populations. As a result of this work, programs managed outside WCFH have started to include children, children with special needs, teens and young families as new initiatives are developed. Examples include collaborative work and planning in the areas of contraceptive and reproductive health; STD prevention;child safety; maternal, infant, and child death reviews; diabetes; tobacco cessation; obesity prevention; and school health.

Division of Health Care Services (HCS): Several years ago a number of Title V programs were moved to the Division of Health Care Services. At that time, the Title V/ CYSHCN Director established a strong collaboration with the Medicaid staff especially in clinical issues and in the development of regulations affecting MCH. Clinical staff from WCFH worked with Medicaid on provider billing, transportation for CYSHCN requiring care in Anchorage or outside of Alaska, consultation and management of dental treatments, home health care regulations and payments for CYSHCN and pregnant women. Although the Title V programs were transferred back to the Division of Public Health, the collaboration with HCS continues especially in the areas of EPSDT-informing, outreach and quality of well child visits. WCFH works closely with HCS in offering direct services for children with genetics, metabolic developmental/autism disorders and those with cleft lip and palate conditions. WCFH continues to bill Medicaid for those clinic services

offered to enrolled children 0-21 years of age.

Health care providers. A strong collaboration between WCFH and health care providers and agencies has been a priority. Working relationships are maintained through advisory committees such as:

- All Alaska Pediatric Partnership (AAP). Contact with health care practitioners, hospitals, clinics and other health care organizations are maintained through this organization. The focus is on delivering high quality hospital and subspecialty services for children throughout the state. Most recently, WCFH provided funding for a study to improve subspecialty service delivery and provider recruitment. See attached draft executive report, "Alaska Pediatric Subspecialty Distribution Plan", May 2010.
- The Newborn Metabolic and Newborn Hearing Screening program advisory committees have also developed strong working relationships with primary care facilities, federally qualified health centers and health care practitioners throughout the state to promote universal screening for all infants regardless of their place of birth in Alaska.
- Breast and Cervical Health Check program maintains links with family planning and specialty clinics, community-based service providers in both the private sector and the native health sector. Website: http://www.hss.state.ak.us/dph/wcfh/bchc/provider/pro_become.htm
- The Perinatal Advisory Committee has links with providers in the private, non-profit, public and tribal health sectors.
- School Nursing Advisory Committee provides support to school nurses across the state to promote universal application of best practices, advocate for school nursing placement in all school districts, support disaster planning efforts and assure that quality, evidence based school nursing care is delivered based on best practice and commensurate with the state's Nurse Practice Act.

Grantees. Community level grantees deliver direct services for WIC, Early Intervention, Breast and Cervical Cancer Screening Outreach, and parent navigation services. WCFH staff has supported community efforts to promote and plan for the health of children and families. WCFH has also provided direct help when significant health problems have occurred in communities with limited resources. There will continue to be a commitment to service coordination efforts and to addressing new challenges of coordination in the future in light of the reorganization of MCH-related programs and initiatives. The primary agency that WCFH works with for parent navigation/coordination services is the Stone Soup Group. WCFH funds parent navigation services for the autism diagnostic center, outreach clinics, the early hearing detection program and families who have children with cleft lip and palate conditions.

Other outside partners include the March of Dimes, The Association of Women's Health, Obstetric and Neonatal Nursing, AAP-Alaska chapter, families, and other non-profit organizations, such as Stone Soup Group, Epilepsy program, FACE, and the YWCA.

Finally, WCFH has a strong relationship with the University of Alaska, both the Anchorage (UAA) and Fairbanks (UAF) campuses. WCFH staff are frequent lecturers in the dental hygiene, human services, nursing, child development, laboratory science and MPH programs. The Section Chief serves on the advisory program for the UAA's MPH program in support of the program's development and future credentialing application and the steering committee for the doctorate of nursing practice. In addition the Center for Human Development at UAA, is a close collaborator in developing programs for CSHCN especially in the area of transition from adolescents to adulthood and intensive treatment services for children diagnosed with autism spectrum disorder.

***An attachment is included in this section.***

## F. Health Systems Capacity Indicators

**Introduction**
The most serious challenge to Alaska's health system capacity is the ability to deliver even basic services to remote rural areas. The second challenge is the ability to offer a full range of subspecialty services statewide. However, the current high level of collaboration among state, private, and non-profit agencies and organizations in coordinating services and pooling resources is a strength that has been acknowledged during the 2010 Needs Assessment process.

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 33.1 | 45.5 | 42.1 | 33.4 | 32.0 |
| Numerator | 97 | 123 | 111 | 88 | 87 |
| Denominator | 29286 | 27062 | 26389 | 26308 | 27148 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
Data Source: Alaska Medicaid. This rate is calculated using Medicaid data.

**Notes - 2008**
Data Source: Alaska Medicaid. This rate is calculated using Medicaid data.

**Notes - 2007**
Source: Alaska Medicaid.

Numerator is Medicaid cases from hospitals for children less than 5 years of age with a diagnosis of asthma (ICD-9: 493-493.92) by state fiscal year (SFY). Denominator is all children under 5 years of age eligible for Medicaid services some time during the SFY reporting period.

**Narrative:**
This measure is based upon Medicaid data and may not be generalized to the overall child population.

The rate of Medicaid-enrolled children under 5 years of age hospitalized for asthma did not significantly change from the prior year. In 2008, according the Alaska Childhood Understanding Behaviors Surveillance, 15.5% of mothers of 3-year old toddlers reported having a child with asthma or wheezing treated with inhalers, puffers or nebulizers.

In 2006 the Maternal-Child Health Epidemiology Unit within WCFH analyzed asthma prevalence, exposure and medication use in children using a combination of Medicaid data, the Hospital Discharge database, and data from the Alaska Behavioral Risk Factor Surveillance System. The analysis was published in "Asthma in Alaska: 2006 Report". Division of Public Health and the Anchorage School District collaborated to introduce asthma questions into school health screening forms, although these data have not yet been analyzed. The SSDI grant was instrumental in establishing capacity for data analysis.

The Alaska Asthma Coalition has implemented public awareness campaigns and worked to achieve successful passage of a bill allowing children to self-administer asthma medications at

school.

One objective for the School Nursing Consultation and School Health program is to conduct a needs assessment during the summer of 2010. Many schools already utilize the national standards, however school nurses have identified a need for education on asthma management and standardizing protocols.

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 86.6 | 88.4 | 86.8 | 84.2 | 88.2 |
| Numerator | 5234 | 5454 | 5006 | 5011 | 5376 |
| Denominator | 6041 | 6173 | 5765 | 5948 | 6093 |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
Data source: Alaska Medicaid, Division of Health Care Services

**Notes - 2008**
Source: Alaska Medicaid

**Notes - 2007**
Data source: Division of Health Care Services

**Narrative:**
Issues related to EPSDT include inadequate staffing for EPSDT outreach in the Division of Health Care Services (HCS). In the past, slow processing of Medicaid enrollment applications were due to inadequate staff and a requirement of re-enrollment every 6 months. During the end of SFY09 HCS changed the regulations to allow enrollment for one year. This helped to improve the turnaround time of enrollment applications; however , because no active outreach and informational program exists for Medicaid enrollees, families are frequently not aware of the EPSDT program and all of its benefits.

In April 2009 the Section of Women's Children's and Family Health implemented a new program, "School Nursing Consultation and School Health , staffed by a school nurse consultant. One component of the program will be education and outreach to families of pre-school and school aged children eligible for Medicaid and EPSDT. The school nurse consultant provides technical assistance to school districts around the state on standards of care and disaster planning. In addition, the consultant will be a liaison for the EPSDT program located in the Division of Health Care Services. It is hoped that outreach to school age children who are eligible for EPSDT exams will improve the number of children obtaining their well child checks.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Indicator | 76.8 | 86.5 | 68.5 | 68.4 | 83.5 |
| Numerator | 63 | 64 | 61 | 52 | 76 |
| Denominator | 82 | 74 | 89 | 76 | 91 |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
Data source: Alaska Medicaid, Division of Health Care Services

**Notes - 2008**
Source: Alaska Medicaid

**Notes - 2007**
Data source: Division of Health Care Services

**Narrative:**
This measure is not useful for Alaska because almost all children fall into the category covered by HSCI #2. The children who would be counted under this measure are those whose Medicaid eligibility status changed thereby making them ineligible for Medicaid, a very small number. (For reporting year 2008, the numerator = 52, denominator = 76). During the end of state fiscal year 2009, eligibility regulations changed from six months to one year, allowing for continuous eligibility for a one year period. It is hoped that this action combined with Medicaid outreach will improve the numbers of children ages 0-21 receiving their EPSDT exams.

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Indicator | 72.7 | 70.0 | 68.5 | 66.0 | |
| Numerator | 7041 | 7108 | 6989 | 6772 | |
| Denominator | 9687 | 10151 | 10203 | 10266 | |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |

**Notes - 2009**
Source: AK Bureau of Vital Statistics. The latest available data is 2008. This calculation is slightly different than how the true Koteclchuck index is calculated. Missing data is excluded.

**Notes - 2008**
Source: AK Bureau of Vital Statistics. The latest available data is 2008. This calculation is slightly different than how the true Koteclchuck index is calculated. Missing data is excluded.

**Notes - 2007**
Source: AK Bureau of Vital Statistics. The latest available data is 2007. This calculation is slightly different than how the true Koteclchuck index is calculated. Missing data is excluded.

**Narrative:**
This indicator has been falling steadily in the last 13 years. The 2008 measure (66%) is 19% lower than the high year of 1995 (81.2%). To address adequate prenatal care and preconception health, a perinatal nurse consultant was hired in FY 2008. A Perinatal Advisory Committee was formed and meets 2-4 times per year. The perinatal nurse consultant held focused interviews in communities with the greatest number of births to assess access to prenatal care and the community standards and attitudes around early and continuous prenatal care. Reports from obstetrical providers to the MCH Title V/CSHCN director indicated the reluctance in some practices to accept prenatal patients who are not yet approved for Medicaid coverage. This resulted in many women reportedly not receiving prenatal care until well into their second trimester. According to PRAMS data, for the women who had problems getting early prenatal care during 2004 - 2005, the main reasons given were: 1) could not get an appointment when they wanted one (30%); 2) the doctor or health plan would not start care earlier (26%); and 3) they didn't have enough money or insurance (23%). Of the mothers who delivered a live birth and were surveyed by PRAMS, 48% said that Medicaid was the payment source for prenatal care and 23% used personal income. With the change late in state fiscal year 2009 of eligibility for one year, it is hoped that efficiencies in processing applications will carry over to processing applications for prenatal coverage as well.

In 2009 the EpiCenter at ANTHC conducted a quality assurance project in one service region in western Alaska. One finding was that prenatal care visits at village clinics were under reported. Forms were changed to facilitate manual data entry. The Perinatal Advisory committee has identified the need to educate hospital staff who completes the birth record form to improve the accuracy of reporting the total number of prenatal office visits during a woman's pregnancy as a priority. In addition, educating providers about the important opportunity in prevention education that exists if prenatal care is initiated early in the first trimester. Topics such as tobacco alcohol and recreational cessation, folic acid/prenatal vitamins and nutrition education and the importance of maintaining a healthy weight can be covered with early initiation of prenatal visits.

## Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 89.3 | 89.1 | 90.3 | 89.3 | 89.2 |
| Numerator | 71571 | 69398 | 65144 | 71468 | 72620 |
| Denominator | 80148 | 77897 | 72175 | 80070 | 81408 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
Data source: Alaska Medicaid, Division of Health Care Services

**Notes - 2008**
Source: DHSS, Division of Health Care Services. This indicator is reported on the 1 through 20 age group, and covers the federal fiscal year.

**Notes - 2007**
Data Source: Division of Health Care Services.

**Narrative:**
In May 2006 the state benefited from a State Leadership technical assistance workshop on ESPDT and Title V Collaboration to Improve Child Health Outcomes. One goal identified was to increase the participation rate of eligible children receiving dental services. Another goal was to increase EPSDT visits among older children. Unfortunately, the Division of Health Care Services did not have a program manager for the EPSDT program for over a year, thus the work on outreach had been only a mildly active approach that included letters of notification to families reminding them of their child's upcoming well-child visit due date.

In the past year, processing time of applications for Medicaid through the Division of Public Assistance has been reduced and the eligibility period has been extended from 6 months to one year. This has greatly improved families' ability to get health care as providers are now requiring proof of Medicaid eligibility in hand prior to an appointment being made. Dental utilization has improved with greater access to dentists who are taking Medicaid and the implementation of the dental health aide program in several Alaskan Native villages.

In April 2009 the Section of Women's Children's and Family Health implemented a new program, "School Nursing Consultation and School Health , staffed by a school nurse consultant. One component of the program will be education and outreach to families of pre-school and school aged children eligible for Medicaid and EPSDT. The school nurse consultant provides technical assistance to school districts around the state on standards of care and disaster planning. In addition, the consultant will be a liaison for the EPSDT program located in the Division of Health Care Services. It is hoped that outreach to school age children who are eligible for EPSDT exams will improve the number of children obtaining their well child checks.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 53.6 | 53.1 | 51.6 | 51.4 | 51.4 |
| Numerator | 9110 | 9000 | 8376 | 8324 | 8535 |
| Denominator | 16999 | 16949 | 16235 | 16192 | 16590 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
Data source: Alaska Medicaid, Division of Health Care Services

**Notes - 2008**
Source: Alaska Medicaid

**Notes - 2007**
Data source: Division of Health Care Services

**Narrative:**
Alaska now has 19 pediatric dentists, however one does not accept Medicaid, one has limited the number of Medicaid children seen, and two have limited practice hours. Therefore, a realistic estimate of full time pediatric dentists is about 16, an increase of two since 2008. We can attribute part of the increase to 3 new pediatric dentists that completed the hospital-based pediatric residency program at Southcentral Foundation/Alaska Native Medical Center.

Private dental participation in Medicaid remains limited especially for new Medicaid patients. There was a reimbursement increase in July 2008, however that didn't result in any noticeable increase in dentist Medicaid participation. There was another reimbursement increase in July 2009. There is no information at this time on whether that had any effect on Medicaid participation.

To fulfill the need for dental services for all people, the Alaska Dental Health Aide Therapist Program was developed as a specialty practice under the Community Health Aide Program (CHAP) and is operated by the Alaska tribal health program. This program is authorized by federal law only for operation in Alaska. There are four categories of dental health aides, all of whom work under the direct or general supervision of a licensed dentist. Training for the Dental Health Aide Therapist program is now offered in Alaska. There are currently 14 Certified DHATs and four in preceptorships. Another seven students are expected to graduate in December 2010.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 100 | 100 | 100 | 100 | 100 |
| Numerator | | | | | |
| Denominator | | | | | |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
All State SSI beneficiaries receive rehabilitative services from the State CSHCN program.

**Notes - 2008**
All State SSI beneficiaries receive rehabilitative services from the State CSHCN program.

**Notes - 2007**
All State SSI beneficiaries receive rehabilitative services from the State CSHCN program.

**Narrative:**
In Alaska, all SSI beneficiaries less than 16 years of age requesting rehabilitative services from the state Medicaid waiver and Developmental Disability waiver programs are eligible for Medicaid. Further, Medicaid covers rehabilitative services for all eligible children (age 0-21) who are SSI beneficiaries. Even if Medicaid is expanded to the 200% of poverty level in Alaska, MCFH anticipates that this population will continue to be covered by Medicaid for rehabilitative services, thereby maximizing the use of Title V to fund other programs and services for CSHCN who are without alternative resources.

## Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of low birth weight (< 2,500 grams) | 2008 | matching data files | 7.4 | 4.5 | 6 |

**Narrative:**
A recent evaluation of birth certificate data by MCH-Epidemiology Unit demonstrated that the proportion of preterm births in Alaska is increasing, primarily due to an increase in medical intervention preterm births. Among Alaska Natives, this increase was met with a concurrent decrease in spontaneous preterm births. This may indicate that high risk Alaska Native births are being better monitored. (Summary available at http://www.epi.alaska.gov/bulletins/docs/b2008_12.pdf) A surveillance program that tracks short- and long-term outcomes among all Alaskan preterm births would help evaluate Alaska's capacity to maximize health outcomes, however, current funding levels of the MCH Title V block grant are not sufficient to add another surveillance program at this time. The Perinatal Advisory committee will be presented with this data at their next meeting to gather thoughts on prevention messages and opportunities for public education as well as health care provider education.

## Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Infant deaths per 1,000 live births | 2008 | matching data files | 7.5 | 4.2 | 5.9 |

**Narrative:**

From 2007 to 2008, the rate of infant deaths per 1,000 live births remained the same among the Medicaid enrolled population (7.5 per 1,000) and fell 14% among the non-Medicaid population. The disparity between the Medicaid and non-Medicaid population increased from 1.5 to 1.8.

Analysis of the Alaska Maternal-Infant Mortality Review (MIMR) data shows that the leading preventable cause of infant death is SIDS/unexplained asphyxia. This is strongly associated with unsafe sleep environments, including co-sleeping. The Section of Women's Children's and Family Health initiated a Safe Sleep Initiative in 2008 to further clarify its recommendations on safe sleep environments and target public education messages to families engaging in high risk behaviors. A stakeholder meeting was held in spring of 2009 and a draft public message was developed in early 2010. Initial work on a social marketing campaign in currently underway to test messages with new mothers in a variety of locations throughout the state. The results of this evaluation will be used to conduct a social marketing campaign that includes culturally appropriate messages in SFY 2011.

Resources:
"Findings of the Alaska Maternal-Infant Mortality Review 1992 - 2001" report available at http://www.epi.hss.state.ak.us/bulletins/docs/rr2006_03.pdf

"Infant Sleep Position and Co-Sleeping in Alaska" Title V Fact Sheet available at http://www.epi.hss.state.ak.us/mchepi/pubs/facts/fs2005na_v1_17.pdf

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 2008 | matching data files | 71.4 | 88.1 | 79.8 |

**Narrative:**
The disparity in the percent of pregnant women entering care in the first trimester between Medicaid and non-Medicaid mothers has remained the same since 2003. About 20% fewer women on Medicaid enter care in the first trimester compared to women not on Medicaid. Among all the women surveyed by PRAMS, problems related to the healthcare system were commonly reported reasons for not getting earlier prenatal care. Nineteen percent of those who reported not getting care as early as desired cited lack of a Medicaid card as a barrier. In addition, turnaround times for Medicaid applications has been an issue in the past. It is hoped that a change in regulations allowing for one year eligibility in the state's SCHIP program will free up staff to process application for pregnant women in a more timely manner.

In 2009 the EpiCenter at ANTHC conducted a quality assurance project in a service region in western Alaska. One finding was that prenatal care visits at village clinics were under reported. This finding is likely to bias the Medicaid count. Forms were changed to facilitate manual data entry.

"Prenatal Care in Alaska" Title V Fact Sheet available at:

http://www.epi.hss.state.ak.us/mchepi/pubs/facts/na/Vol1_Num12.pdf

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) | 2008 | matching data files | 64.6 | 67.4 | 66 |

**Narrative:**
The percentage of pregnant women with adequate prenatal care (as measured by the Kotelchuck Index) continued to drop slightly in both groups, by about the same amount. Program changes to improve these numbers are found in the discussion under Capacity Indicators.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

| **INDICATOR #06** **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Infants (0 to 1) | 2009 | 175 |
| **INDICATOR #06** **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Infants (0 to 1) | 2009 | 175 |

**Notes - 2011**
There are few children in the SCHIP 0 - 1 age range. Only babies who were not born to mothers on Title XIX Medicaid. Babies born to mothers on Medicaid are funded under Title XIX Medicaid for the first year and are reflected in the Medicaid eligibility level table.

**Narrative:**
From 2003 to 2009 the eligibility threshold for Denali KidCare, the state's SCHIP program, was frozen at 175% of the 2003 federal poverty level, with no adjustments for the cost of living. In the ensuing years, inflation reduced the effective eligibility levels and more than 2,500 beneficiaries lost coverage.

In 2009, after repeated attempts to increase eligibility, legislation was passed to increase the income eligibility to 175% of the current federal poverty and to keep it current with changes in the cost of living. Several legislators were also supportive of increasing eligibility to at least 200% of

poverty level and during the SFY2010 legislative session, a bill did pass to increase the level to 200% of poverty with the governor's support. However, the governor reversed himself, stating that he only recently learned that "Medicaid pays for abortions". Despite attempts to clarify the payment methodology (all state funds are used; only abortions that are deemed medically necessary; state law requiring abortions be covered in the Medicaid program, etc.), the legislative representatives opted not to attempt a veto override. Thus the SCHIP program will stay at 175% of poverty.

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Medicaid Children<br>(Age range 1 to 19)<br>(Age range  to )<br>(Age range  to ) | 2009 | 175 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Medicaid Children<br>(Age range 1 to 19)<br>(Age range  to )<br>(Age range  to ) | 2009 | 175 |

**Narrative:**
From 2003 to 2009 the eligibility threshold for Denali KidCare, the state's SCHIP program, was frozen at 175% of the 2003 federal poverty level, with no adjustments for the cost of living. In the ensuing years, inflation reduced the effective eligibility levels and more than 2,500 beneficiaries lost coverage.

In 2009, after repeated attempts to increase eligibility, legislation was passed to increase the income eligibility to 175% of the current federal poverty. See HSCI #6A for further information.

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Pregnant Women | 2009 | 100 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Pregnant Women | 2009 | 100 |

**Notes - 2011**
Pregnant women are not funded under Title XXI, CHIP.

**Notes - 2011**
Pregnant women are not funded under Title XXI, CHIP.

**Narrative:**
From 2003 to 2009 the eligibility threshold for Denali KidCare, the state's SCHIP program, was frozen at 175% of the 2003 federal poverty level, with no adjustments for the cost of living. In the ensuing years, inflation reduced the effective eligibility levels and more than 2,500 beneficiaries lost coverage. Pregnant women are not funded under Title XXI, CHIP.

In 2009, after repeated attempts to increase eligibility, legislation was passed to increase the income eligibility to 175% of the current federal poverty. See HSCI #6A for further information.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

| **DATABASES OR SURVEYS** | **Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)** | **Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)** |
|---|---|---|
| ANNUAL DATA LINKAGES<br>Annual linkage of infant birth and infant death certificates | 3 | Yes |
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files | 3 | Yes |
| Annual linkage of birth certificates and WIC eligibility files | 2 | No |
| Annual linkage of birth certificates and newborn screening files | 3 | Yes |
| REGISTRIES AND SURVEYS<br>Hospital discharge survey for at least 90% of in-State discharges | 3 | No |
| Annual birth defects surveillance system | 3 | Yes |
| Survey of recent mothers at least every two years (like PRAMS) | 3 | Yes |

**Notes - 2011**

**Narrative:**

Alaska's MCH data capacity is very good. The SSDI grant was instrumental in developing data linkages that significantly increased capacity for research, analysis and evaluation.

Examples of data linkages include:
- Linking the newborn hearing screening and newborn metabolic screening programs to facilitate efficient tracking and follow-up of infants needing referrals and services.
- Linking birth certificate and WIC data to research risk factors for high rates of anemia in Alaska Native children.
- Linking Medicaid data and death certificates for infant, child and maternal mortality review.
- Linking Medicaid records, law enforcement reports and child protective services reports for the child abuse and maltreatment surveillance system.

Some data sources need improvement. Data from the Trauma Registry will be available when the Section of Chronic Disease Prevention and Health Promotion has completed verifying and correcting the data. The Hospital Discharge database is not as complete as desired because of less than full participation from all hospitals. The numbers of hospitals participating continues to increase however. In the Title V agency, there is improved access to Medicaid claims information and Medicaid pharmacy billing data for research and analysis.

The State of Alaska is developing a new Medicaid Management Information System that will be effective Summer 2011. The new system will cover 10 years of data and have additional fields.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

| DATA SOURCES | Does your state participate in the YRBS survey? (Select 1 - 3) | Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N) |
|---|---|---|
| Youth Risk Behavior Survey (YRBS) | 3 | Yes |

**Notes - 2011**

**Narrative:**
The Youth Risk Behavioral Survey (YRBS) is conducted through a cooperative effort between the Section of Chronic Disease Prevention and Promotion and the Department of Education and Early Development. It has been administered every two years since 1995, except in1997.

Alaska requires active parental consent law for children to participate in school surveys. The survey was administered in 2001, but unfortunately low student response rates rendered the data unusable. Districts indicated that the new requirement for signed (active) parental permission in 2001 was the primary reason for the low response rate. In 2003 the survey was administered statewide with active parental consent and representative data were obtained, making this the first statewide YRBS representative sample since 1995. The survey was again administered in 2005, however the response rate fell just below the target and the data was not used. In 2007 and in 2009, the survey was administered and achieved an adequate response rate, yielding important survey results. The next survey will be administered in 2011.

In 2009 two surveys were conducted - one among traditional high schools and, for the first time, one among alternative high schools. Fifteen alternative schools were chosen to be included in the survey and 1,020 students completed the survey. The school response rate was 100 percent and the student response rate was 71 percent, resulting in an overall response rate of 71 percent. Since Alaska's Department of Education and Early Development (EED) presently manages

several federal grants that require it to direct services and resources to Alaska's most at-risk student/youth populations, it became essential to conduct a statewide alternative schools YRBS to determine if our state's alternative schools profiled consistently with the national alternative schools. The data indicates Alaska alternative schools report similar levels of risk behavior to the National Alternative Schools Survey of 1998. The results of this survey provides EED with the credible data to best direct its at-risk initiatives, to determine the level of risk behaviors present in this student population, to advocate for needed supports, and to measure any progress made in decreasing student risk behaviors as a result of its interventions. It is anticipated these data will also be invaluable to Alaska's alternative schools on a local level as they seek to provide empirical evidence for any needed additional resources.

The 2009 survey questionnaire is available at http://www.hss.state.ak.us/dph/chronic/school/pubs/2009AKHQuestionnaire.pdf.

# IV. Priorities, Performance and Program Activities

## A. Background and Overview

The Five-Year Needs Assessment was completed in FY 2010. State priorities for 2010 - 2015 are:

1. Reduce substance abuse, including alcohol, tobacco and drugs, among families.
2. Reduce child maltreatment and bullying.
3. Collaborate with families and others to work toward a system of integrated services for families with infants, children, and teens, and especially those with special health care needs..
4. Reduce the risks associated with unintended pregnancy and teen pregnancy.
5. Reduce dental caries in children 0 - 21 years of age.
6. Reduce intimate partner violence (IPV) including teen dating violence.
7. Reduce risk factors associated with preventable post-neonatal mortality due to SIDS/asphyxia.
8. Support communities to increase family and youth resiliency.
9. Reduce the prevalence of obesity and overweight throughout the lifespan.
10. Increase universal screening for post partum depression in women.
11. Strengthen quality school-based health care and health promotion.
12. Implement standardized screening for developmental delay and behavioral health in children 0 - 21 years.
13. Develop capacity to help families navigate the health care system.
14. Acknowledge the importance of men in MCH programs.
15. Reduce late preterm cesarean sections

For the most part, state priorities did not change significantly from the 2005 Needs Assessment. Issues of mental health, education, family resiliency and delivery of health care in rural areas are reflected in the state priorities concerning outcomes in substance abuse (#1), child maltreatment (#2), teen pregnancy (#4), intimate partner violence (#6), post-neonatal mortality (#7), chronic conditions (#5, #9), and post partum depression (#10).

New priorities focus on expanding access to services by increasing system efficiency (#3), increasing navigation assistance (#13), and promoting new systems (#11, #13). The State continues to expand implementation of the Early Childhood Comprehensive Systems which supports priorities 1,2, 3, and 8. The ECCS Plan was approved and adopted by the Department of Health and Social Services Commissioner and the Children's Policy Team.

The trend of increasing late preterm cesarean sections, similar to national trends, is an emerging issue (#15). Another emerging issue is incorporating a lifecourse perspective and making the family unit (using very broad definitions of family) to focus on risk and protective factors of the family unit (#14).

Since 2005 the state's MCH program continued to grow in capacity in areas identified as priority in 2005. New programs added include the Adolescent Health Program, School Health Program, Perinatal Health Program, and the Pediatric Neurodevelopmental Outreach & Autism Screening Clinic. Two new surveillance programs were established - the Childhood Understanding Behaviors Survey (CUBS) and the Surveillance of Child Abuse and Neglect (SCAN). The Child Death Review was re-established to examine deaths of children 1-14 years of age.

These programs support state priorities 2, 3, 4, 6, 7, 11, 12, 13 and 15. The new programs translate to increased ability to pursue grants, expand health education, assess needs, and create partnerships.

CUBS is one of the newest surveillance programs, launched in FY 2006, in response to community and staff concerns on early childhood health. It is a PRAMS follow-up survey that

provides population-based data on pre-school aged children in Alaska. The goal is to evaluate the association between prenatal and immediate postnatal factors with early childhood health and welfare. The current survey is of mothers of three year olds. Alaska is only one of four states surveying the health and developmental status of toddlers. The linkage of PRAMS and CUBS provides opportunities to look at longitudinal data. Both surveys include the same questions about maternal mental health to track state performance measure #10, to support universal screening for post partum depression.

To address the state priority of reducing the rate of child abuse and neglect, a new surveillance program, the Alaska Surveillance of Child Abuse and Neglect (Alaska SCAN) was created in 2007. The program resides within the MCH-Epidemiology Unit. The goal is to provide reliable, accurate, and consistent data of child maltreatment through an integrated and centralized data depository. The Alaska SCAN system links data from various organizations which include, but are not limited to, hospital in-patient records, emergency department records, police and homicide reports, child death review findings, and child protect services reports. This systematic collection of information and application of standardized, sensitive public health definitions promotes data consistency over time. Data from SCAN will also be used to implement, monitor, and evaluate scientifically-based, community focused initiatives, as well as advocate for resources based on reliable and consistent information.

The Alaska MIMR has been instrumental in improving health outcomes of infants since the early 90's. The analysis of risk factors associated with SIDS/unexplained asphyxia led to bed-sharing recommendations contrary to those of the American Academy of Pediatrics. The state has implemented a Safe Sleep Initiative to further clarify its recommendations.

## B. State Priorities

Focus will continue to be on prevention and early intervention services related to family violence, child abuse and neglect, young children's access to health care and reduction of unplanned pregnancy. The MCH Epidemiology Unit has primary responsibility to collect and analyze data, and to conduct evaluation and research activities.

State priorities are as follows (not listed in order of importance):

Priority #1. Reduce substance abuse, including alcohol, tobacco and drugs, among families.

Performance Measures:

- Percent of women (who delivered a live birth) who had one or more alcoholic drinks in an average week during the last 3 months of pregnancy. (state)
- Percent of students who smoked cigarettes on 20 or more days during the 30 days before the survey (state)
- Prenatal smoking (smoking in the last 3 months of pregnancy) is a national performance measure.

Infrastructure Building Services:

- An interdivisional preconception/interconception planning committee was initiated in 2009 to improve women's health during the adolescent years through preconception, prenatal and postpartum time periods. Smoking cessation, alcohol and substance abuse prevention are topics of focus.
- Usage of iq'mik and commercial spit tobacco, popular among the Alaska Native population, is collected through PRAMS.

Population Based Services:

- WCFH staff collaborates with the local March of Dimes chapter on the preterm delivery campaign to develop smoking cessation classes with hospitals and local agencies and to develop

support systems for women who are pregnant.

- Programs such as reducing and preventing underage drinking; rural substance abuse prevention; and tobacco enforcement and youth education are managed by the Division of Behavioral Health.
- The Alaska Tobacco Control Alliance operates the free Tobacco Quit Line. WCFH staff provide data and input into public media campaigns and quit line support to include stop smoking cessation messages for pregnant women.

Priority #2. Reduce child maltreatment and bullying.

Performance Measure:

- Rate of reports of maltreatment per thousand children under age 18 years. (state)

Infrastructure Building Services:

- Data sharing agreements are being pursued with partner agencies to fully implement the Surveillance of Child Abuse and Neglect.
- WCFH continues to collaborate with other state agencies: 1) expand Strengthening Families model statewide; 2) implementation and evaluation of the ECCS program; 3) pursue grant opportunities such as Project Launch and home visitation programs.
- WCFH is collaborating with the Office of Children's Services on the ECCS program and is one of two Division of Public Health representatives on the Interdepartmental ECCS committee.

Priority # 3. Collaborate with families and others to work toward a system of integrated services for families with infants, children, and teens, and especially those with special health care needs.

Performance Measure:
None at this time.

Infrastructure Building Services:

- There is interagency collaboration in the Alaska Early Comprehensive Childhood Systems (ECCS) Plan developed by the Office of Children's Services.
- The Section Chief of WCFH (Title V/CYSHCN Director) and program staff work closely with primary health care staff responsible for FHQCs and community health centers to ensure needs of children, pregnant teens and CSHCN are considered in their delivery of services.
- The Autism and Parent Services Manager actively works with parent representatives to develop integrated programs. In collaboration with Family Voices and the Family to Family project at the Stone Soup Group, a parent advisory group meet or conference call in to discuss the system of care for CYSHCN.

Population Based Services:

- The Section Chief of WCFH (Title V/CYSHCN Director) will continue to participate with the All Alaska Pediatric Partnership in the identification of pediatric sub specialty needs and recruitment so that specialized care can be offered closer to the child's home community.

Enabling Services:

- Parent navigation services are offered through a grant with the private non-profit group, Stone Soup Group, and parent navigators have been trained in several communities to assist families. Parents are active on the Autism Alliance Ad Hoc committee and Steering committees, the Epilepsy steering committee (coordinated by the Center for Human Development at the University of Alaska-Anchorage), and all advisory committees sponsored by WCFH.

Direct Services:

- WCFH continues to sponsor genetics, metabolic, cleft lip/palate, autism screening, and neurodevelopmental disorder clinics in communities throughout the state, based on need.

Priority # 4. Reduce the risks associated with unplanned pregnancy and teen pregnancy.

Performance Measure:
- % of women who recently delivered a live birth and are not doing anything now to keep from getting pregnant. (state)
- Rates of teen pregnancy, 15-17 years of age, is a national performance measure.

Population Based Services:
- WCFH staff provides information and training for health care providers and public health professionals on contraception counseling pregnancy prevention and intimate partner violence prevention. Training is offered at professional association meetings, providers offices and at tribal community health aide training.

Enabling Services:
- WCFH collaborates with the Division of Public Assistance on their teen and out-of-wedlock pregnancy prevention program by sponsoring provider training for IUD and Implanon insertion techniques, contraceptive supplies and educational materials especially where rates of teen and out-of-wedlock pregnancy are highest.
- Title V monies fund three nurse practitioner contracts for family planning services in areas of the state where access is minimal.

Priority # 5. Reduce dental caries in children 0 - 21 years of age.

Performance measure:
- Percent of mothers who report tooth decay in their 3-year old child.

Infrastructure Building Services:
- The state's Dental Officer works with the Alaska Dental Society on workforce development issues to expand access to dental services in rural Alaska, administering contracts with pediatric dental providers to increase access to services for children enrolled in Medicaid/SCHIP, participating in the development of the tribal Dental Health Aide Program, and developing pediatric resident itinerant rotations in Alaska.
- The State's Dental Officer participated in the development of the tribal Dental Health Aide Program and in the development of pediatric resident itinerant rotations in Alaska.
- An Oral Health Survey of kindergartners and third graders is conducted every two years but is dependent upon grant funding.
- The State's Dental Officer oversees the enrollment of pediatric dental providers in support of increasing access to services for children enrolled in Medicaid/SCHIP.

Priority #6. Reduce intimate partner violence (IPV) including teen dating violence.

Performance measure:
- Percent of high school students (grades 9-12) who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the 12 months before the survey.
- Percent of women who recently had a live-born infant and reported experiencing intimate partner violence before, during or after pregnancy.

Infrastructure Building Services:
- PRAMS, CUBS, BRFS and YRBS provide some data on different aspects of IPV but there is no comprehensive surveillance system to measure the burden of IPV on MCH populations.
- The Adolescent Health Manager is an active participate in the CDC's Domestic Violence Prevention Enhancements and Leadership Through Enhancements (DELTA) program which addresses intimate partner violence.

Population Based Services:

- This issue is addressed primarily through the Family Violence Prevention Project. The MCH Title V block grant funds staff who oversee the resource center that contains materials on education and prevention of domestic violence.
- The Adolescent Health Manager is actively involved in promoting education around teen dating violence. A teen advisory committee will collaborate with the Domestic Violence Network in rural and bush locations to decrease teen dating and intimate partner violence.
- In FY2010 the Governor declared domestic violence to be a priority and new legislation strengthened laws concerning domestic violence and sexual assault.

Priority # 7. Reduce risk factors associated with preventable post-neonatal mortality due to SIDS/asphyxia.

Performance measure:
- Percent of mothers who recently delivered a live birth and who reported having one or more environmental factors in the home that are associated with SIDS/unexplained asphixia. (Environmental factors include laying baby down to sleep on side or stomach; baby sleeps with pillows, plush toys, etc; smoking allowed in home) (state)
- A related indicator is the National outcome measure #4, postneonatal mortality rate per 1,000 live births.

Infrastructure Building Services:
- Data from the Maternal Infant Mortality Review (MIMR) is provided to programs, health care providers and communities for program planning and education that focus on prevention related activities such as the Back to Sleep and Never Shake a Baby campaigns.
- A Safe Sleep coalition was formed in 2009 to work on the issues of safe sleep of all Alaska infants. Cultural sensitivity will be applied to social messaging.

Population Based Services:
- The state has actively engaged all birthing facilities to participate in educational campaigns.

Priority # 8. Support communities to increase family and youth resiliency.

Performance measure:
- Percent of youths who reported a parent talks to them about school once or twice a month or more.

Infrastructure Building Services:
- The Adolescent Health program manager actively collaborates with many state and private organizations to develop programs for building youth assets. Stand Up Speak Up will be evaluated this year.

Enabling Services:
- The Stand Up Speak Up campaign to encourage teens to speak out against violence is a collaboration with DELTA, the Alaska Council on Domestic Violence and Sexual Assault, and CDC.
- A teen advisory group, the Youth Alliance for Healthy Alaskans (YAHA), was formed by the WCFH Adolescent Health program manager to advise on teen programs. A YAHA-led mini-summit on prevention of teen pregnancy was held as part of the 2010 Title V Needs Assessment process.
- The Adolescent Health program manager co-sponsors Lead On! with the Alaska Network on Domestic Violence & Sexual Assault. This is a state-wide group of youth and adults who are interested in promoting non-violence and equality in their communities (website: http://www.andvsa.org/?page_id=530) . The Lead On! mini-summit scheduled for October 2010 will include many activities to teach teens leadership skills.

- A grant has enabled a Peer Helper program in Mat-Su schools so teens can teach a curriculum on pregnancy prevention.
- The Section of Chronic Disease Prevention and Health Promotion manages grant programs focused on youth asset building and suicide prevention. For example, the Anchorage Youth Development Academy trains adults who want to learn youth development strategies.

Priority # 9. Reduce the prevalence of obesity and overweight throughout the lifespan.

Performance measure:
- Percent of mothers who report their 3-year-old child had a BMI greater than the 85th percentile (overweight and obese). (state)

Infrastructure Building Services:
- The Section of Chronic Disease and Prevention collaborates with Anchorage School District to analyze the prevalence of overweight and obesity among school age children. WCFH is investigating ways to incorporate weight surveillance statewide through other programs.
- Obesity is a priority for the interdivisional preconception and interconception planning teams
- WCFH participates in the Mayor's Task Force on Obesity in Anchorage.
- Nutrition education is disseminated through the WIC program.

Priority # 10. Increase universal screening for post partum depression in women.

Performance measure: Percent of women who delivered a live birth and had a provider talk to them about post partum depression since their new baby was born. (state)

Infrastructure Building Services:
- PRAMS and CUBS surveillance programs continue to be a source of data on mental issues for women surrounding the pregnancy period and for women with toddler-aged children. A significant increase in capacity to address this issue is needed.
- The MCH Title V Director participates on the DHSS Commissioner's Child Policy Team which is focused on improving instate access and infrastructure of behavioral health services. In addition, the MCH Title V Director is actively involved on the steering committee and subcommittees for the ECCS grant focused on behavior health training, access and financing strategies.

Priority # 11. Strengthen quality school-based health care and health promotion.

Performance Measure:
None at this time.

Infrastructure Building Services:
- An advisory committee of school nurses has been established. A needs assessment will be conducted in Fall 2010. These efforts will dictate future activites and performance measures.

Priority # 12. Implement standardized screening for developmental delay and behavioral health in children 0 - 21 years.

Performance measure:
- Percent of children enrolled in Medicaid receiving EPSDT screening. (state)
- HSCI #2 (% of Medicaid enrollees whose age is less than one year who received at least one initial or periodic screen)
- HSCI #7b (% of EPSDT eligible children aged 6 through 9 receiving any dental health service during the year).

Infrastructure Building Services:

• WCFH participated in the ABCD national initiative. An interdepartmental committee led jointly by the Title V Director and the manager of the ECCS program is developing a proposal to require the use of either Ages and Stages or the PEDDs in an EPSDT well child exam as a requirement for Medicaid payment.

Population Based Services:
• The same interdepartmental committee is recommending the use of MCHAT or CHAT for toddler autism screening. Education regarding developmental screening is offered to tribal community health aides and practitioners. Additional training modules for early interventionists, nurses, and other direct health care providers is offered or in development.

Enabling Services:
• Federal grant funds from the Combating Autism Grant and some Title V MCH monies are used to purchase resource materials, screening tools and sponsoring professional education. Outreach education to parents emphasizes well child screens with developmental components.

Priority # 13. Develop capacity to help families navigate the health care system.

Performance Measure:
None at this time.

Enabling Services:
• Parent navigation services are offered through a grant with a private non-profit group. The Stone Soup Group, and parent navigators have been trained in several communities to assist families.
• Parents are active on the Autism Alliance Ad Hoc committee, the Epilepsy steering committee (coordinated by the Center for Human Development at the University of Alaska-Anchorage), and the neurodevelopmental planning committee, all coordinated within WCFH.

Priority # 14. Acknowledge the importance of men in MCH programs.

Performance Measure:
None at this time. This new priority. It reaffirms the continued emphasis on centering health around the family. We will develop ideas over the upcoming five year planning period on how to incorporate this priority, and develop capacity, in MCH programs.

Priority # 15. Reduce late preterm cesarean sections

Performance measure:
• Number of cesarean births delivered at 34 - 36 completed weeks of gestation per 100 total births. (state)

Infrastructure Building Services:
• Infrastructure activities include monitoring trends using PRAMS and Vital Statistics data, and research regarding health outcomes of the infants.

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 92.6 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 25 | 36 | 44 | 195 | 115 |
| Denominator | 27 | 36 | 44 | 195 | 115 |
| Data Source | | | | Alaska Newborn Metabolic Screening Program | Alaska Newborn Metabolic Screening Program |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2009**
Data source: Alaska Newborn Metabolic Screening

**a. Last Year's Accomplishments**
The percent of infants screened in the State in CY2009 was 100%. The program manager continued with educational efforts that addressed collection techniques, confirmatory testing requirements, and specimen transport time. These educational presentations often included continuing education credits. All of the conditions diagnosed through the newborn metabolic screening program are reportable to the Alaska Birth Defects Registry; the program manager provided the registry with this information on a quarterly basis.

All infants identified with sickle cell disease, carnitine defects, amino acid disorders, and CAH in CY 2009 were referred to the Genetics and/or Metabolic Clinics conducted by the State of Alaska. Parents of children with these disorders were scheduled for genetic counseling and advice on their child's disorder.

The number of confirmed cases of CPT-1 continued to increase. The educational DVD was widely distributed to families with infants identified with CPT-1 through screening and to health providers in the villages providing care for these infants. More than 90 confirmed cases of a carnitine disorder called CPT-1 are found in the Alaska Native population again this calendar year. Biochemical geneticists from Oregon are working with Alaska physicians to try to determine the significance of this new finding. Because all infants to date have been from either western or northern Alaska, collaboration with Alaska Native Tribal Health Consortium has been implemented. The NBMS Advisory Committee held its regular 3x/year meetings with discussions on CPT-1 lead by physicians on the advisory and presentations on infant formula issues and the process for the Title V Needs Assessment.

Activities for work with the Western States & Territories Genetics Collaborative included attending an annual meeting and working on the logic model for our region. The addition of a parent representative supported the goal of improved coordination and education for families.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue with education and communication for providers on tandem mass spectrometry disorders. | | | X | X |
| 2. Continue education and monitoring of specimen quality to assure a high level of screening is conducted. | | | X | X |
| 3. Provide community education through presentations at hospitals, birthing centers, professional organization meetings, and health fairs. | | | | X |
| 4. Refer infants identified with disorders detected through the screening program to State-sponsored Genetics and/or Metabolic clinics. | X | | | |
| 5. Provide information on reportable conditions to the Alaska Birth Defects Registry on a quarterly basis. | | | | X |
| 6. Convene the Newborn Metabolic Screening Advisory committee on a three times per year basis to develop policies and review the program activities. | | | | X |
| 7. Continue to work with the EHDI web-based database vendor to enhance the reporting and searching function of the metabolic integration. | | | | X |
| 8. Initiate a task force to look at issues surrounding CPT-1. | | | X | |
| 9. Continue with active participation on the Western States & Territories Genetic Collaborative grant to improve access and education about genetics services in Alaska. | | | X | X |
| 10. Continue collaboration with Alaska Native Tribal Health Consortium and Oregon Health & Science University to educate families and medical staff around the state regarding CPT-1 and by distribution of the DVD developed to enhance this process. | | | X | X |

**b. Current Activities**

As infants are identified through screenings with fatty acid oxidation disorders and organic acidemia disorders, we refer the parents of the child to the Genetics and/or Metabolics Clinics conducted by the State of Alaska. Whereas, infants identified with hypothyroidism and CAH are referred to the Alaska based pediatric endocrinology clinic and started on treatment.

To date for CY09, there are several infants diagnosed with hypothyroidism, CAH, and two fatty acid oxidation deficiencies. We send the educational DVD on CPT-1 deficiency to each newly identified infant's family to educate the family on the condition and importance of the treatment plan.

The NBMS Advisory Committee holds its regular meetings three times per year. During this meeting, 2 local nutritionists (who were sent to the Metabolic University in Colorado) provide educational reports. This is in part to train nutritionist who travels for the metabolic clinic. In addition, we are working with a local neonatologist to update the NICU screening protocol.

Ongoing educational efforts include presentations to physicians, nurses, and laboratorians at hospitals and professional organizations regarding the screening program, proper collections techniques, and proper follow-up testing of presumptive positive screens.

Database integration merging newborn hearing screening with metabolic screening into one child health record is in place and being used to track infants and provide reports.

**c. Plan for the Coming Year**
We anticipate the need for continuing education efforts regarding the lesser-known conditions identified through expanded testing with tandem mass spectrometry as well as new conditions being recommended by the Secretary of HHS Advisory Committee on Heritable Disorders in Newborns and Children. Most important will be education on the confirmatory testing process including proper specimen collection and shipment to the appropriate testing facility.

The Newborn Metabolic Screening program manager has been nominated for a seat on the Secretary's HSS Advisory Committee. If seated, the program manager will become a source of information for the State Newborn Metabolic Screening Advisory Committee on recommended conditions and position statements.

The Newborn Metabolic Screening Advisory Committee will continue to meet to discuss concerns and issues surrounding newborn screening, future trends, and emergency preparedness.

Ongoing work with the Western States & Territories Genetics Collaborative and other children's health programs including EHDI Program, Specialty Clinics and Genetics and Birth Defects Clinics will continue during this next year. The Parent Support Services Manager is an active participant on the Western States & Territories Genetics Collaborative.

These are enabling and infrastructure-building activities.

## Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

| **Total Births by Occurrence:** | **11611** | | | | | |
|---|---|---|---|---|---|---|
| **Reporting Year:** | **2009** | | | | | |
| **Type of Screening Tests:** | **(A) Receiving at least one Screen (1)** | | **(B) No. of Presumptive Positive Screens** | **(C) No. Confirmed Cases (2)** | **(D) Needing Treatment that Received Treatment (3)** | |
| | No. | % | No. | No. | No. | % |
| Phenylketonuria (Classical) | 11611 | 100.0 | 7 | 1 | 1 | 100.0 |
| Congenital Hypothyroidism (Classical) | 11611 | 100.0 | 26 | 8 | 8 | 100.0 |
| Galactosemia (Classical) | 11611 | 100.0 | 4 | 0 | 0 | |
| Sickle Cell Disease | 11611 | 100.0 | 2 | 2 | 2 | 100.0 |
| Biotinidase Deficiency | 11611 | 100.0 | 2 | 0 | 0 | |
| VLCAD | 11611 | 100.0 | 1 | 1 | 1 | 100.0 |
| Medium-Chain | 11611 | 100.0 | 1 | 1 | 1 | 100.0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Acyl-CoA Dehydrogenase Deficiency | | | | | | |
| Amino Acids (excluding PKU) | 11611 | 100.0 | 16 | 0 | 0 | |
| CPT-1 Ddficiency | 11611 | 100.0 | 97 | 97 | 97 | 100.0 |

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 63 | 61 | 61 | 61 | 61 |
| Annual Indicator | 57.2 | 57.2 | 51.8 | 51.8 | 51.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | Child and Adolescent Health Measurement Initiative | Child and Adolescent Health Measurement Initiative |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 61 | 61 | 65 | 65 | 65 |

**Notes - 2009**
/2011 Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2008**
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2007**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**a. Last Year's Accomplishments**
During the last year, we partnered with the Stone Soup Group (SSG) to work with the parents of Alaska's children and youth with special health care needs (CYSHCN0. This essential enabling service held a pivotal role and provided critical support to families as they learned new terminology, understood new billing systems, and acquired the needed information to make

informed decisions. As a grant with the SSG agency, parent navigators aided families as they navigated the system with their children who attended an outreach clinic for screening or the Providence Autism Diagnostic Network (PADN) for a diagnosis. Through follow-up, the SSG parent navigators supported families as they completed forms, got on "wait-lists," and made recommendation for alternatives when the system didn't respond in a timely manner.

Specifically, the parent navigation services continued for cleft lip / palate (CL/P), early hearing detection initiative (EHDI) clinics, and the pediatric neurodevelopmental (PND) clinics. Title V funded parent navigators' travel with medical providers to outreach clinics; while there, they assisted families who needed financial resources, shared options, and helped guide parent after a treatment plan was made. Post-clinic satisfaction surveys from the CL/P clinic in FY 09 showed that 77% of families who responded felt that services offered at clinics were excellent and family-centered; post-clinic surveys for genetic/metabolic clinics revealed that 88% of families thought services were above average or excellent and family-centered. The PND clinic created and distributed a survey of client satisfaction but no surveys were returned. Staff made changes to increase the return rate in calendar year 2010.

In addition, parent navigators were integral member of the Providence Autism Diagnostic Network (PADN) and The Children's Hospital at Providence Neurodevelopmental Center. Trained to work with families using the principles of family-centered care, they worked as the liaison with the medical provider and the family to tailor a care plan that would best meet the needs of the child. As families faced the intensity of a full workup for an autism diagnosis, parent navigators supported and continued to work with families until they were understood the importance of the documentation, multiple evaluations, and numerous appointments. When the medical provider conducted the post-evaluation report-out, the parent navigator took notes for the family and relayed valuable details that the family missed. Then, the parent navigator worked to implement the care plan.

Last year, a CPT-1 deficiency DVD was distributed (which had been created the previous year) to families and health care providers as a response to families in rural Alaska where there appears to be a higher regionalized diagnostic rate. Early results of an investigation resulted in the need for families and providers in the area were unaware of the trend and needed more information. That DVD contained information that educated for parents and providers on the importance of screening and intervention. The DVD proved to be very helpful as it addressed the an unusual higher diagnosis trend in northwest AK.

A parent advisory committee was established and meetings were held to discuss the family and CYSHCN concerns. They reviewed current Title V national performance measures and the State of Alaska's (SOA) activities. They shared feedback on continued challenges as a parent of CYSHCN. This was a joint effort by Title V staff and SSG who represented Alaska Family Voices.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue to hold clinics in public health centers, at the Children's Hospital at Providence, and in clinic spaces easily accessible to parents. | X | | | |
| 2. Provide patient services for clinics (referrals, scheduling, travel, medical record collection, and follow-up). | X | | | |
| 3. Continue support of parent navigation services with MCH Block Grant funds for CL/P, hearing loss, and for children diagnosed with autism and other neurodevelopmental conditions. | | X | | |
| 4. Update and regularly administer client/family satisfaction | | | X | |

| | | | | |
|---|---|---|---|---|
| surveys for the genetic, PND, and CL/P clinics. | | | | |
| 5. Continue parent involvement on MCH supported Perinatal and CYSHCN advisory committees; support and recruit teens for new advisory committees for adolescents. | | | | X |
| 6. Coordinate with UAA center for Human Development to improve access to care providers as a workforce development effort and include parents in designing curriculum in their training. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Section of Women's Children and Family Health represents the needs of Title V initiatives in the SOA within the Division of Public Health. Using the principles of the pyramid model for program development, the SOA examines family and CYSHCN concerns in infrastructure building and population based services. Added this year to the MCH staff is a school health nurse consultant, an expansion of adolescent health, and an autism public health specialist.

Valuing family input, we survey parents to determine their satisfaction in the genetic, metabolic, CL/P and the pediatric neurodevelopmental (PND) clinics. We also successfully implemented quarterly meetings with the SSG parent navigators. In addition to discussing current needs and trends families share, we discuss system improvements that will aid families at the critical juncture of screening and diagnosis. In addition, the Parent Support Services Manager has initiated a family advisory committee in collaboration with the state's Family Voices representative.

New staff and parent navigation are at various levels of funding levels of the Title V MCH Block Grant.

**c. Plan for the Coming Year**

In the coming year we will continue to expand and increase the number of children seen in the PND clinics in public health centers throughout Alaska, bringing pediatric developmental specialists and parent navigators to the families. This improvement process improves access to screening and navigation services. Additionally, genetics, metabolic, and CL/P clinics will be held in Anchorage, Fairbanks, and Southeast Alaska.

Anchorage-based coordinators will continue to develop and manage the details of the clinics. Staff will accept referrals, schedule patients, arrange travel, collect medical record document and provide follow-up as needed. At the CL/P and the genetic clinics, parent navigation will continue to be offered as a service to both the newly diagnosed and those families returning for follow-up services. As part of the Combating Autism Act Initiative, we will continue to focus on early screening and identification so that with a diagnosis, long-term outcomes can improve.

As documents, educational tools, and promotional materials are developed for CYSHCN, they will be distributed as part of population-based services. Awareness building leads to improved screening and the importance of following up with families where concerns are identified. Clear communications is needed to encourage families who may be afraid of processes or diagnoses. The importance of screening, early intervention, and therapeutic services for CYSHCN will significantly improve long-term quality of life issues.

The genetic, PND and CL/P clinics will continue to refine the survey process to increase the number of respondents. As recommendations come in, the suggestions will be implemented as

time and resources allow. Building on the parent advisory committees for CYSHCN, continue to recruit a cross section of parents and meet, guiding meaningful discussion and projects. As the adolescents and perinatal care committees continue to meet, encourage the committees to include adults with special healthcare needs to ensuring a comprehensive view of needs.

As families report that accessing services is the most challenge need they face, the SOA will continue to support work-force development initiatives in collaboration with the University of Alaska Anchorage Center for Human Development. As a joint effort, we will continue to support post graduate trainings, certifications, and endorsements as part of the solution to the crisis of not enough service providers to meet needs. New degrees with an emphasis in developmental disabilities may be added to the school of psychology. Further, collaboration with the University of Washington's LEND program will continue; in-fact, they are fully supportive of a planning grant submission for a LEND site in Alaska. A significant part of the trainings and LEND development infuses family-centered care principles in training direct service staff.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 54 | 50 | 50 | 45 | 45 |
| Annual Indicator | 46.5 | 46.5 | 39.3 | 39.3 | 39.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | Child and Adolescent Health Measurement Initiative | Child and Adolescent Health Measurement Initiative |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 45 | 45 | 45 | 45 | 45 |

**Notes - 2009**
/2010/ 2011/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2008**
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Since the annual indicator for prior years is not comparable to the indicator for the current year. The objective should be revised to reflect the new measurement.

**a. Last Year's Accomplishments**

During the last year, we focused our efforts for coordinated and comprehensive care for CYSHCN rural Alaska. Alaska's healthcare is built on a regional hub system of tribal healthcare. We used the core public health services delivery model for MCH agencies when building the foundation for population-based and enabling services delivery. Each rural regional hub uniquely controls their healthcare delivery based on tribal preferences, experiences, and staffing. The challenges the hubs face in keeping consistent workforce contributed to the average that rural Alaskans were often 24-36 months older in identification of a neurodevelopmental disorder. Therefore, we tested an intensive expansion of the pediatric neurodevelopmental outreach and autism screening clinics.

We recognized that Alaska's 17 regional systems of care condensed to 11 hub centers; we committed extensive staff and resource to bridge each of the health systems in 1:1 communication and established agreements with all sites eventually. Each regional hub required sensitivity to personnel and procedures and successful negotiations with the centralized Alaska Native Tribal Health Consortium (ANTHC) in Anchorage.

We succeeded in getting an agreement for clinical expansion to all rural Alaska regional hubs. We successfully negotiated with each regional hub, thereby families and tribal health leaders were assured that this one-stop service was coordinated and comprehensive within their home community. Because we brought the specialist to the regional hub, screened the child in their home clinic, and then wrote report with recommendations based on local resources, the family with a CYSHCN had their needs met and maintained within their community. Dates for calendar year 2010 were set for an aggressive schedule of 11 sites (9 new) and a total of 20 days. The PND clinics were scheduled for the hub communities of Dillingham, Bethel, Soldotna, Valdez, Kodiak, Barrow, Ketchikan, Juneau, Fairbanks, Kotzebue and Nome. Most of these villages have populations less than 3500 people.

Other examples of coordinated care delivery in the form of clinics include the Cleft Lip and Palate (CL/P) clinic. It continued both in Anchorage and Fairbanks. This clinic utilized the on-going care of highly skilled providers in the dental, surgical, and nutrition fields. Again, families were able to come to one location and see all the necessary specialists. This too demonstrated highly effective system of care that coordinated around the needs of child and the family conveniently.

Further, the genetic clinics were held at Alaska Native Medical Center (ANMC), offering families the opportunity to revisit providers who have seen their child previously or had access to the child's extensive chart; this too, maintained on the concept of the medical home, kept a highly specialized care plan up-to-date and in one place. Additionally, the ANMC serves as the medical home for routine care of many families living in very rural Alaska.

During the last year, the Early Hearing Detection Initiative (EHDI) program educated primary care providers within the medical home ANTHC hub centers about hearing loss detection protocol. The protocol states that when a child or family is identified with a hearing loss, providers are to refer to parent navigator services to aid the family in meeting goals regarding early intervention services. Communication with a medical home and primary care providers on protocol was key to a successful 100% screening of all births in FY 2010.

Stone Soup Group (SSG) parent navigators continued to work closely and collaboratively with

clinic coordinators based in Anchorage. Parent navigators traveled to the clinics along with medical staff. They met with families and provided information on resources or distributed timely educational materials across all the SOA clinic services. Further, SSG parent navigators helped families arrange travel to Anchorage for comprehensive diagnostic evaluations and assisted families as they navigated funding agencies.

The medical staff providing the screenings or medical services wrote reports that were sent to both the family and the primary care provider. This assured that there was consistent communication back to the medical home. The families were also given a copy of the SSG parent navigator recommendations.

Title V MCH Block Grant funds support these efforts.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Collaborate with and educate community providers on new resources available for CSHCN, specifically those affected on the autism spectrum. | | X | | |
| 2. Continue parent navigation services (PNS) for parents of children with cleft lip and palate, infants or children identified with hearing loss, and those children of all ages affected by autism and other pediatric neurodevelopmental needs | | X | | |
| 3. Explore and develop a plan for expanding parent navigation services for other specialty conditions in collaboration with medical home. | | X | | |
| 4. Evaluate and adjust pediatric neurodevelopmental and autism screening clinics at the 9 expanded sites and make adjustments in the available number of appointments based on the needs identified during initial expansion. | X | | | |
| 5. Monitor flexibility and appropriateness of clinics held in public health centers making adjustments to better serve families in the community / facility where the clinics are held. | | X | | |
| 6. Educate primary care providers regarding newborn hearing screening regulations and the protocol regarding infants/children identified with hearing loss. | | | X | |
| 7. Ensure infants identified with a metabolic disorder on newborn screening receive care from the State sponsored metabolic genetics clinics. | X | | | |
| 8. Monitor developing regional trends of the carnitine palmitoyl transferase deficiency disorder and work with public health officials to educate the public of the concern. | | | | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

As specialty clinic services develop, considerable effort is being made to include the family's medical and healthcare delivery system at the hub regional care level. For example, itinerant PHN's may serve a very rural family as the medical home. Improvements to their I-link teleconference equipment gives the itinerant nurse new options to communicate and collaborate on rural healthcare delivery.

Another example, physicians, rural providers, and the family are being closely followed for

abnormal screenings of the carnitine palmitoyl transferase (CPT1)deficiency. Through collaboration with the hub service provider, we are seeing an unusual trend which is being followed closely.

The SOA autism program continues in their work of expanding the PND clinics. During this year, the clinic went to Anchorage and Fairbanks and also the rural hubs sites of Ketchikan, Kodiak, Dillingham, Bethel, and Soldotna. Clinics will be held shortly after the start of SFY 2011 in Valdez, Barrow, Kotzebue, and Nome.

The SOA/WCFwill continue to sponsor genetics clinics in Sitka, Ketchikan, and Juneau in public health centers and CL/P clinics in Anchorage and Fairbanks. The metabolic clinic will continue to hold clinics in Anchorage and Fairbanks; however careful evaluation of the number of days needed will be monitored based on the needs of newborn screening referrals.

These services are direct health care, enabling, population-based and infrastructure

**c. Plan for the Coming Year**

In fiscal year 2011, we will have 8 strategic measures designed to ensure that children with SHCN will receive coordinated, comprehensive and on-going care based on the medical home model.

We intend to collaborate and educate rural community health and medical care providers on new resources, specialists, service providers, and program planning for CYSHCN. Specifically those affected by autism, a concerted effort will continue as radio and television PSA's. We will continue to enhance the SOA autism web site and continue with agency and provider site visits at each of the hub regional care centers. We will offer training and support to individual agencies, schools, and providers that will be tailored to the specific audience. Infrastructure building services will assure that families will have access to an increase of highly educated workforce, funding for services, and culturally sensitive treatment plans.

As the PND clinics expand and are held in new locations, we will be implementing an evaluation process to ensure that the outreach clinic services are meeting the needs of rural families. By examining the number of referrals, appointments made, and the numbers actually seen, we can evaluate the root cause of no-shows or the declination of services that were offered to the family. Once we understand why families decline services in a culturally context, we can adjust service offerings appropriately.

When a child is diagnosed with a hearing problem, it is essential to have up-to-date and accurate referral information in the hands of the primary care provider, or the medical home hub community provider. We will continue to work to ensure providers have the most current and accurate information available.

As children test positive for metabolic conditions, specifically CPT-1 deficiency disorder, we will monitor trends and seek recommendation for interventions and public service awareness building. Working together with public health colleagues, we will educate the public on the importance of follow-up testing and intervention. If there continues to be a concentration of positive diagnosis of CPT-1deficiency disorder, we will explore with researchers familial trends and increase public health services to that region.

Parent navigation services will continue to be an important and useful tool to provide directly to families as they need to have a successful course of treatment for their child in their home community. Additionally, the SSG agency is hiring additional staff for a 1-800 number so that families in crisis have resources to discuss and solve real-time parenting concerns like a child having a temper tantrum. These program developments offer a continuum of services so that the

family has a strong foundation of choices as they cope with their child's developing needs.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 60 | 60 | 60 | 70 | 70 |
| Annual Indicator | 58.6 | 58.6 | 62.2 | 62.2 | 62.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | Child and Adolescent Health Measurement Initiative | Child and Adolescent Health Measurement Initiative |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 70 | 70 | 70 | 70 | |

**Notes - 2009**
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2008**
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2007**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**a. Last Year's Accomplishments**
Insurance information was collected and tracked for all children accessing state-sponsored services for children and youth with special healthcare needs (CYSHCN). MCH collaborated and advocated for the needs of CYSHCN with Alaska's Denali KidCare (DKC) and Medicaid programs. A contract with the Alaska Native Tribal Health Consortium (ANTHC) provided Indian Health Services (IHS) funds as payer of last resort for genetics and specialty clinics services. TriCare (Department of Defense) covered the cost of clinic visits for military dependents referred to state-sponsored clinics. We also documented the number of families who self-pay, do not have insurance, or don't pay for services based on a sliding fee scale.

At the cleft lip and palate (CL/P) clinic, 72% received government funded aid in the form of Medicaid/Denali Kid Care, or Tri-care; 27 % were privately insured and 1% were self-pay. At the neurodevelopmental outreach and autism screening clinics, 60% were Medicaid/Denali KidCare or Tri-Care; 7% were self-pay and 33% had private insurance pay for the services. Finally, our database combined the metabolic and genetics clinics pay sources. It reported that last year 59% of children were insured with Medicaid/DKC or IHS funds; only 32% were funded with private insurances; and both the self-pay or no charges due to inability to pay were 2% each. There was an unknown factor of 5% who were being processed, declined, or alternates payment was considered but not yet resolved.

In summary, all 4 clinics combined averaged as 63% public funding from Medicaid/ Denali KidCare, TriCare, and HIS funding. Private insurance accounted for just 31%. Self-pay, no charge, and unknown accounted for the balance of 7% across all the MCH and SOA sponsored clinics.

The Mental Health Trust funded starter hearing aids for loaning purposes. This funding will not t continue after SFY 2010. The Early Hearing Detection and Identification (EHDI) program also placed screening and testing equipment in the public health nursing centers. It was used by nursing staff for families who delivered their newborn outside of a hospital, suchas a home birth or in a midwifery center. Additionally, the equipment was used to re-screen children who did not pass the initial screening and were already discharged from the hospital.

CL/P also conducted activities last year to support CYSHCN through outreach clinics held in Anchorage and Fairbanks that helped families who needed funding for special feeding supplies. As a result of collaboration with Medicaid the previous year, special feeding supplies were covered. In addition, negotiations and work continued with the Division of Health Care Services to expand Medicaid coverage for nutritional supplements and food for children born with metabolic conditions. These efforts will also include planning for new formulas that are available on the market for children identified with metabolic conditions at birth.

Last year's community-based advocacy resulted in improvement in Alaska Medicaid/DKC access. Enrollment regulations were changed to allow 12 months of continuous eligibility for children up to 175% of FPL. Bills were introduced into the Alaska legislature that would raise eligibility from 175% to 200% FPL. Efforts were also made to streamline the application process for newly pregnant women who needed assistance through Medicaid. Continued collaboration and monitoring was required as data was sought on the number of women were denied access to funds due to implementation of the Federal Debt Reduction Act.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Collect and track insurance information for all children accessing state-sponsored CSHCN services. | | | | X |
| 2. Contract with ANTHC to provide IHS funds as payer of last resort for specialty clinics services. | X | | | |
| 3. Provide genetics, metabolic, CL/P, and neurodevelopmental clinics services regardless of ability to pay; offer reduced fees for self –pay families based on income. | X | | | |
| 4. Work with the military on referrals and authorizations to include their beneficiaries in state-sponsored clinics. | | | X | |
| 5. Bill Medicaid as appropriate for CSHCN who attend state-sponsored specialty clinics. | X | | | |

| | | | | |
|---|---|---|---|---|
| 6. Continue to work with Medicaid to cover additional formulas for infants identified with metabolic conditions. | | | X | |
| 7. Continue to provide deaf or hard-of hearing children access to hearing aids if families do not have third-party coverage. | X | | | |
| 8. Work with the Division of Public Assistance to streamline and improve the processing of the applications of newly pregnant women seeking healthcare. | | | X | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The state-sponsored CSHCN clinic programs are collecting data regarding insurance for children who attend the clinics through a database management system. We are working to update the data collection system and considering a variety of options.

Parent navigation througha state grant with the SSG will continue. SSG navigators are successfully working with families who attend state-sponsored clinics. Parent navigators continue to be integral in assisting families with the applications process and managing the system to gain timely access to services.

Advocacy continues for a autism waiver; additionally, a mandatory health insurance coverage bill is moving through the legislative process. Community organizers, the Children's Hospital at Providence and the All Alaska Pediatric Partnership will work on educating the public and Alaska legislative body to expand the Denali KidCare's FPL from 175% of the FPL to 200%. An estimated 1100 children would become eligible for services. Efforts on HB 187 legislation also continue. The Division of Public Health is supportive of these efforts.

The Title V MCH Director is working with staff in the Medicaid office to track the numbers of children and pregnant women affected by the requirements for citizenship and birth validation as a result of the Deficit Reduction Act. Title V staff are committed to monitoring the effects of healthcare reform (HCR) for all women and children as well.

**c. Plan for the Coming Year**
In the coming year, we will continue be vigilant in monitoring access to services as the result of HCR efforts. As new dollars are infused and systems access these moneys, we will be alert and attentive in our representing of women and children, especially those with SHCN.

In Alaska, we will continue our collaborative relationship with the Alaska Tribal Health Consortium (ANTHC), Alaska Section of Healthcare Services, and SOA Rural Healthcare Committee to ensure our family's needs are met with adequate funding of services.

As part of the needs for CYSHCN, we anticipate on-going meetings and collaborations with the SOA Medicaid office to cover special formulas and foods for child with metabolic disorders. Further, we will continue to contract with ANTHC as a payer of last resort for families living in rural Alaska. TriCare will continue to be an important resource to our families for accessing services as military dependants. We will monitor new policies or procedures associated with this funding source so that military families have access to all the services that are available. We will continue to provide services to families of CYSHCN regardless of their ability to pay.

Tracking and monitoring through the data management system will continue, with possible upgrades and the inclusion of newer content. Investigating better systems to more accurately describe service delivery, especially for autism, is a goal we will focus on for the coming year. As part of the combating autism act initiative dollars, we are hoping to make a more direct correlation

between the outreach clinics efforts and Providence's Autism Diagnostic Network exams. This type of focus will give us feedback on best practices within the SOA unique healthcare delivery system.

The EDHI program will be working to find alternative funding for loaner first hearing aids for children who are hard of hearing or deaf. This is a valuable and important program to continue and locating a funding source will be a priority.

We will also continue our successful work by offering genetic, metabolic, CL/Palate, and neurodevelopmental outreach clinics, serving families of CYSHCN because of renewed energy and new working relationship emerging with healthcare providers in rural Alaska. We will continue to partner with parent navigators from the SSG in these clinics as they have a finger on the pulse of funding resources and new strategies associated with the highly structured process of applying for funding.

We intend to continue our close working relationship with SSG using Title V dollars for infrastructure building and population based activities that are essential services to our families.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 75 | 75 | 90 | 90 |
| Annual Indicator | 73.3 | 73.3 | 85.1 | 85.1 | 85.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | Child and Adolescent Health Measurement Initiative | Child and Adolescent Health Measurement Initiative |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |

**Notes - 2009**
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2008**

/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2007**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Since the annual indicator for prior years is not comparable to the indicator for the current year. The objective should be revised to reflect the new measurement.

**a. Last Year's Accomplishments**
We continued to refine and improve upon many of the activities that were initiated in FY08. We also focused on increased collaboration and relationship-building between State of Alaska agencies, sections, and departments along with community-based services providers on a wide variety of services to meet the needs of CYSHCN.

For example, an emphasis on early screening and intervention for children with neurodevelopmental concerns complimented several federal initiatives. These initiatives provided resources and a clear focus for implementing one of the 5 steps of the 2006 State of Alaska (SOA) Autism Plan. Through meetings, conferences, and subcommittee work, a collective energy emerged that made a significant impact on early screening, detection, and treatment efforts. In addition, we saw a significant reduction in "wait lists."

Last year the SOA Title V efforts within public health used the MCH Pyramid and focused on infrastructure building by conducting environmental scans, evaluations and assessments, and set standards of care. We worked to get people to the table in meetings, summits, and conferences to talk about challenges families were facing as they moved between systems and services. Relationship improvements emerged between key stakeholders, including Early Intervention / Infant Learning Program, Public Health Nursing, Stone Soup Group, Special Education Service Agency, Department of Education and Early Development, the military, ANTHC, ANMC, Mental and Behavioral Health Systems, Adolescent Health, Medicaid, Universities and schools districts. This resulted in a reduction of confusion for families because of a new focus on transitions, i.e. seamless system of services.

Further, the Title V/CSHCN Director and the Children's Health Unit Manager were active participants in the All Alaska Pediatric Partnership, a community coalition of hospitals and medical providers serving the pediatric population of the state. The Partnership successfully worked together to recruit pediatric specialists that improved service access. For example, pediatric dental residents were included as part of their fellowships to work in the CL/P clinics. The SOA efforts succeeding in linking other specialty services like speech therapy, perinatology, and genetic counseling. As a result of data shared by the Title V program, justification to hire pediatric endocrinology, an additional pediatric surgeon, a pediatric gastroenterologist and two additional perinatologists were recruited.

In partnership with the Alaska Native Medical Center and the Alaska Tribal Health Consortium, the SOA made significant progress in building bridges to partner in service delivery.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue contracts to deliver specialty clinics statewide. | X | | | |
| 2. Assure culturally appropriate and family-centered services by | | | X | |

| | | | | |
|---|---|---|---|---|
| holding an experiential workshop for families and providers to work together on improved communication. | | | | |
| 3. Provide professional medically-trained interpreters to translate for non-English speaking families during specialty clinic appointments. | | X | | |
| 4. Maintain and update non-English resources for families to understand the medical conditions their child is being seen for as part of specialty post-clinic reports and education. | | | X | |
| 5. Continue service delivery by co-supporting a genetic counselor to based at the Alaska Native Medical Center and SOA MCH offices. | X | | | |
| 6. Continue parent navigation grant to assure families are linked to resources such as support groups, providers and financial aid programs. | | X | | |
| 7. Offer a venue for health care professionals to get training at specialty clinics. | | | X | |
| 8. Collaborate with UAA Center for Human Development to improve community providers working with children to understand the warning signs of autism and how to refer a child and their family for further assessment. | | | X | |
| 9. Maintain a parent advisory group that will include all children with SHCN, including children with developmental disabilities, asthma, cancer, CF, and diabetes. | | X | | |
| 10. | | | | |

**b. Current Activities**

Parent navigation services are a huge success of this year's program efforts. New staff, expanding services, and improving training led to highly satisfied parents survey results. Parent navigation services are meeting the needs of families in creative / out-of-box thinking. Similar to case management, this non-profit agency was able to build strong relationships and meet the families without the hindrances of specific protocol so often associated with private offices and publically funded healthcare delivery systems.

In part, the SSG success in bridging the gaps is the result of the successful parent advisory group which now includes families beyond the DD community. We now have families with asthma, cancer, diabetes, and epilepsy that participate in conference calls. These families are able to share concerns and educate SOA MCH staff of current trends, challenges, and needs. Having open dialogue with families ensures an effective system of care that is recognizable, easier to enter, and more coordinated. The formulation of this group was done in coordination with the state's Family Voices representative.

Adapting to the changing roles of PHNs, we made successful transitions for rural clinics and built new parameters around clinical expansion. Now serving in the role as host, PHN's are in a better position to see more CYSHCN in the field and making appropriate referrals to the clinics.

**c. Plan for the Coming Year**

In the coming FY11 fiscal year, we will continue to offer statewide specialty clinics. We will evaluate the outreach clinic utilizations and make changes as necessary. These outreach clinics are intended to serve as a tool to improve early screening, identification, and service delivery to families as direct healthcare services. Then, continuing efforts for transitional services, we want to continue towards the goal of seamless service delivery across systems and agencies.

Recognizing that the SOA is a melting pot of highly developed cultures, many languages, and a blend of races, especially from the Pacific Rim, seamless service delivery has to incorporate high

sensitivity to cultural diversity. In the coming year, we will continue to provide interpreters during outreach clinics and intend to improve provider skill set for delivering culturally sensitive services.

As federal resources from the CAAI were awarded, the SOA found success in efforts to integrate services across a continuum of care. The SOA Title V Director is an active leader involved in the All Alaska Pediatric Partnership, recognizing the group's ability to have invested stakeholders at the table where decisions are being made. As additional funding sources emerge, targeting recruitment for pediatric subspecialists physicians and ANPs. Coupling federal funding with recruitment efforts, a comprehensive continuum of care emerges that appears as seamless transitions for families.

Using technical assistance support from HRSA/MCHB, we will hold an all day workshop as a post-conference for the SOA MCH conference focused on cultural competency. This workshop will spend 1/3 of day with parents, coaching and mentoring them to self-identify important values within their family and learn the skills to ask for services that compliment them. Approximately 2/3 of the day will be dedicated to care providers, focusing on self-discovery of bias and communication behaviors. At the end of the day, we hope that families will become more consistent in how they ask for services based on their family's values and culture; coupling that with more self-awareness from service providers, we hope to see improvements across systems and agencies as they deliver services.

In addition, the electronic age is giving far more opportunities to network, review, and use effective training and educational brochures. Excellent publications that have already been translated in multiple languages are a highly effective and cost saving way to approach improvements in communication across written publications. We will also support resource developments at the SSG and SESA in their quest to find other education tools to better meet the needs of culturally diverse families with CYSHCN.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 1.5 | 1.5 | 1.5 | 50 | 50 |
| Annual Indicator | 1.1 | 1.1 | 42.2 | 42.2 | 42.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | Child and Adolescent Health Measurement Initiative | Child and Adolescent Health Measurement Initiative |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or | | | | Final | Final |

| Final? | | | | | |
|---|---|---|---|---|---|
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 50 | 50 | 50 | 50 | 50 |

**Notes - 2009**
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2008**
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

**Notes - 2007**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Since the annual indicator for prior years is not comparable to the indicator for the current year. The objective should be revised to reflect the new measurement.

**a. Last Year's Accomplishments**
During the summer months, a meeting was held to determine the Governor's Council on Disabilities and Special Education (GCDSE) next year's program and training planning. A significant issue for CYSHCN in transition was the need for training in money management and financial literacy. Using the Medicaid Infrastructure Grant, they held a successful workshop. They researched national curricula and adapted it to meet Alaska-specific standards.

During the summer of 2009, a 2-day planning meeting was held and a national expert, who co-authored the book, "Transitional Aged Youth and Youth Adults with Behavioral Health Needs" led a workshop that was co-hosted by the GCDSE and Alaska's Mental Health Trust. The emphasis, especially on children and youth in the foster system, was an excellent effort to begin the talk about needs, realities, and wishes of our CYSHCN in transition. Dr. Clark's 2-day workshop enveloped and incorporated the realities of the Alaska youth who were recruited to participate. Their voice was significant and instrumental in what became the start of an Alaska Youth in Transition plan. Dr. Clark came back to Anchorage and continued conversations with the stakeholders in planning in the fall. Minutes from the meeting served as the framework for the plans outline. This workshop morphed out of the "Facing Foster Care in Alaska" project.

Alaska's Statewide Special Education Conference again offered workshops for special education teachers on transition -- a topic both the beneficiaries of the GCDSE and teachers who serve Alaska's children asked for. In addition, trainings were offered to local business and agencies who expressed interest in being a sight for Disability Mentoring Day. The GCDSE worked with the State commission on Community Service new opportunities for youth and young adults to gain work experience through volunteerism. Youth and young adults with disabilities continued to need additional job skill development. Both the GCDSE, using their Youth Transition Coordinators, continued their collaborative efforts with case managers; DVR continued to employ a vocational transition coordinator who helped youth to work before and after the end of high school. In addition, the new Adolescent Health Public Health Specialist in the Section of Women's, Children's and Family Health worked with GCDSE on youth and transition issues as part of the development of adolescent health and healthy relationships training.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Increase connectivity among local and statewide stakeholders. | | | X | |
| 2. Continue Intermediaries' work with local organizations to improve outcomes for youth with disabilities. | | X | | |
| 3. Increase visibility of youth with disabilities within the larger scope of youth employment. | | | X | |
| 4. Develop web links for teens and parents of teens to assist in accessing services. | | | X | |
| 5. Be a technical assistance resource for youth and parents when working with systems and providers. | | | X | |
| 6. Develop a financial literacy curriculum that would be easy to use and distribute it among providers, parents, and teachers. | | | X | |
| 7. Support the State Commission on Community Service to open up new volunteer opportunities for youth with disabilities. | | X | X | |
| 8. Continue the Bring the Kids Home Initiative, ensuring kids with severe emotional disturbance can be served in Alaska. | | | X | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The GCDSE continues to collaborate, train, and coordinate with the Alaska community to improve the lives of youth/ young adults in transition. The SOA Transition Subcommittee continues with the help of Dr. Clark to create a plan to aid Alaska's youth in foster care. The list serve for Youth with Barriers continues to serve as the vehicle to share information on health, transportation, education, work, and housing resources.

The GCDSE hopes to expand to new communities a Disability Mentoring Day - a valuable day to raise awareness on the importance of hiring youth with disabilities. Council staff continues efforts in schools and businesses to match young people in transition with appropriate mentors. Volunteerism as a means of gaining work experience continues to be a meaningful tool in gaining job skills. AmeriCorps, VISTA, and other national service member organizations continue to be a rich resource of both placement opportunities and to share the message of the benefits of hiring youth with disabilities.

GCDSE continues to offer tracks on transition at the Statewide Special Education Conference and the youth liaison will continue to sit on the Workforce Investment Board's Youth Council. This youth liaison bears the crucial role of influencing policy decisions made by the Alaska Workforce Investment Act grantees. The Adolescent Advisory Committee of WCFH will add youth with disabilities to their membership to assure representation of DD issues.

**c. Plan for the Coming Year**

During FY 11 the GCDSE will continue to network with agencies and businesses; advocate to the Alaska State Legislature; and educate the public on ways to improve the lives of youth with disabilities. As the protected and federally mandated Council, in essence, they serve as an intermediary in representing needs, creating programs, spending resources, seeking legislative solutions, and advocating politically for CYSHCN.

Within the larger scope of needs for youth and young people in transition, the GCDSE will continue the successful efforts started in the Youth with Barriers in Transition list serve; expand to a Statewide Disability Mentoring Day; repeat financial literacy workshops through the department of labor and center for human development; continue to offer at the Alaska Statewide Special

Education Conference a tract on youth and young adults with disabilities in transition; and finally, continue to plan and develop the transition age youth and young adults with behavioral needs subcommittee.

A GCDSE youth liaison will continue to sit on the Alaska Workforce Investment Board's Youth Council and continue the work of being the representative to influence decisions affecting youth in transition. Through the WCFH youth advisory committee, youth and young adults with disabilities are being actively recruited to represent the special issues and needs of this population.

Technology and internet resources will continue to be the vehicle to deliver important new information about resources and for networking.

Youth and young adults with disabilities will continue to need meaningful job skill training and work experience. Through a coordinated effort with the GCDSE, DOL, Alaska Special Education Department, DVR, and the State Commission on Community Service, volunteer opportunities, work placement, mentorship days, and educational workshops will continue to keep the good work that's been started.

Efforts of the Bring the Kids Home project will continue to overlap with some of the efforts of the Transitional age youth with behavioral health needs. This unique group of children with SED and living outside Alaska need special advocacy and voice to ensure that Alaska's their transition back into the community is possible and that adequate access to services, respite providers, and housing is available.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 85 | 85.5 | 86 | 86.5 | 87 |
| Annual Indicator | 75.4 | 73.5 | 78.6 | 76.2 | 76.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | | CDC National Immunization Program | CDC National Immunization Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 87 | 87 | 90 | 90 | 90 |

**Notes - 2009**
Source: CDC National Immunization Program, Immunization Coverage in the US, Immunization Survey, NIS Data: Tables, Articles & Figures. (See the 4:3:1:3:3 series).

This covers CY 2008 which is the latest available data.

**Notes - 2008**
Source: CDC National Immunization Program, Immunization Coverage in the US, Immunization Survey, NIS Data: Tables, Articles & Figures. (See the 4:3:1:3:3 series).

**Notes - 2007**
Source: CDC National Immunization Program, Immunization Coverage in the US, Immunization Survey, NIS Data: Tables, Articles & Figures. (See the 4:3:1:3:3 series).
http://www2a.cdc.gov/nip/coverage/nis/nis_iap.asp?fmt=v&rpt=tab03_antigen_state&qtr=Q1/2007-Q4/2007 accessed 3/16/2008.

The most recent data available for this performance measure is 2007. NIS data for 2008 will be available for the 2011 BG submission

**a. Last Year's Accomplishments**
A 30 second TV PSA promoting the importance of childhood immunization featuring the Governor, "On Time Every Time", was produced and aired statewide in Alaska.

VacTrAK, the state immunization information system (IIS) recruited and enrolled new providers and provided assistance with system integration allowing practices with and without electronic medical records (EMR) to participate in VacTrAK. Population and demographic data is downloaded into VacTrAK from Alaska Vital Statistics and Permanent Fund sources. VacTrAK now contains record of nearly 3 million vaccinations.
In Alaska all H1N1 vaccination activity was recorded in VacTrAK. Providers who wished to administer H1N1 vaccine were required to enroll in and submit usage reports to VacTrAK. All H1N1 vaccine distribution and inventory control was accomplished using VacTrAK.

Alaska statues requiring immunization for childcare and school attendance were revised. Children entering grades K through 6 are now required to have record of receiving 2 varicella vaccinations. The requirement for the tetanus/diphtheria booster (within 10 years of last Td vaccine) was changed to now require that that vaccine be Tdap (tetanus/diphtheria/acellular pertusis). The new requirements became effective on July 1, 2009.

The 2009 Alaska Recommended Childhood & Adolescent Immunization Schedule was updated. This is done every year to include any recommendation changes recommended by the FDA Advisory Committee on Immunization Practice (ACIP). In 2009 the ACIP recommended that all children age 6 months through 18 years should receive annual influenza vaccination.

Self ImmAGE, Alaska-specific school and childcare immunization compliance software, was launched as a web-based application. School nurses and Head Start/childcare staff can now access this helpful software online to calculate compliance status of their facilities.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Participate in the statewide 2010 MCH/Immunization Conference. | | | | X |
| 2. Present and/or exhibit at statewide childcare, professional association, and Head Start conferences and at community events. | | | | X |
| 3. Update Alaska-specific childhood & adolescent recommended immunization. | | | X | X |

| | | | | |
|---|---|---|---|---|
| 4. Collaborate with the Iditarod Trail Committee to put on the annual childhood immunization awareness campaign, “I Did It By TWO. | | | | X |
| 5. Present vaccine & immunization lectures to University of Alaska nursing & nurse practitioners students. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Alaska Immunization Program is changing the state-supplied Tdap vaccine from Adacel™ (licensed age range 11-64 years) to Boostrix™ (licensed age range 10-64 years). Also, the childhood pneumococcal vaccine now protects against 13 virus strains. Prior to 2010 this vaccine contained 7 virus strains.

The Alaska Immunization Program is participating in the statewide 2010 MCH/Immunization Conference. Immunization topics to be presented include addressing provider and parental vaccination hesitancy and information on the adolescent vaccination.

Staff of the Alaska Immunization Program are presenting and/or exhibiting at statewide childcare, professional association, and Headstart conferences and at community events.
Alaska-specific childhood & adolescent recommended immunization schedules are updated for 2020 to reflect current ACIP recommendations.

The annual childhood immunization awareness campaign, "I Did It By TWO!", is again put on in collaboration with the Iditarod Trail Committee, taking advantage of the largest event in Alaska every year.
Staff of the Alaska Immunization Program present vaccine & immunization lectures to University of Alaska nursing & nurse practitioners students.

**c. Plan for the Coming Year**

The Alaska Immunization Program will put on a statewide Immunization Conference in May, 2011. Specific topics to be covered include but are not limited to vaccine safety, vaccine storage & handling, VacTrAK, national & state immunization update.

Vaccinate Alaska Coalition, The Alaska Immunization Program, and the Iditarod Trail Committee will again collaborate to put on the annual Alaska childhood immunization awareness campaign, "I Did It By TWO!", in winter/spring 2011.

Staff of the Alaska Immunization Program will present and exhibit at professional association and other conferences (AAP, AAFP, ANA, AAEYC, AK Pharmacists), and at community events (annual Baby & Toddler Fair, Health Fairs, Head Start Health Advisory meetings).
Staff of the Alaska Immunization Program will present immunization lectures to University of Alaska nursing & nurse practitioners students.

Vaccinate Alaska Coalition and the Alaska Immunization Program will develop, produce, and produce Alaska-specific VAC-FACT provider education 1-pagers. The topics to be covered include the adolescent vaccination platform, childhood & adult pneumococcal vaccination, and updated influenza vaccination for 2010-11 season.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 19 | 18 | 18 | 18 | 18 |
| Annual Indicator | 17.3 | 18.6 | 16.0 | 18.3 | |
| Numerator | 289 | 315 | 271 | 301 | |
| Denominator | 16681 | 16919 | 16888 | 16439 | |
| Data Source | | | | AK Bureau of Vital Statistics | AK Bureau of Vital Statistics |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 18 | 18 | 18 | 18 | 18 |

**Notes - 2009**
Source: Alaska Bureau of Vital Statistics. 2008 is the latest available data

**Notes - 2008**
Source: Alaska Bureau of Vital Statistics. 2008 is the latest available data

**Notes - 2007**
Source: Alaska Bureau of Vital Statistics.

**a. Last Year's Accomplishments**
The birth rate for teenagers aged 15-17 years in Alaska was 18.3 births per 1,000. The Healthy Alaskans 2010 Objective is 18 per 1,000.

Title V continued to fund nurse practitioners to provide comprehensive reproductive health services, including comprehensive education and counseling, at the Kodiak Public Health Center (PHC) and the Juneau High School Teen Health Center, one of Alaska's two school-based clinics. USPSTF guidelines were strictly adhered to, to assure appropriate, client-centered reproductive health care for women in this program.

Title V funds also were used for cervical cancer screening services for women of all ages seeking family planning services at all State PHCs in addition to the Kodiak PHC, following USPSTF guidelines. Women with abnormal screening results were referred to the Alaska Breast and Cervical Health Check program for diagnostics and/or treatment as needed.

The WCFH Family Planning Program (FPP) continued to administer the Title X Family Planning Services grant in FY09, offering high quality, low cost family planning and related preventive health services to low income women, men, and teens in communities in the Mat-Su Valley and the lower Kenai Peninsula. The FPP Title X services promoted parental involvement in teen decisions to seek family planning services and offered comprehensive sexuality education and counseling, including encouraging abstinence, as a core part of their service delivery.

The Section of WCFH continued work under an interdepartmental agreement with the Division of Public Assistance with the goal of reducing teen and non-marital pregnancy in Alaska. Under this agreement, the FPP and the Adolescent Health Program (AHP) targeted the issues of teen pregnancy and unhealthy relationships by promoting healthy relationships in Alaska's teens. The AHP conducted a statewide needs assessment with Alaskan youth and service providers. The AHP also provided administrative support for three grants to communities aimed at involving youth in the prevention of teen pregnancy and unhealthy relationships. The AHP promoted teen pregnancy prevention through radio PSAs.

The AHP served as an active member of a domestic violence and sexual assault prevention steering committee, linking violence prevention and pregnancy prevention for teens. The AHP established a wide network of collaborating agencies with which it is consistently collaborating and planning future work. In addition, the AHP helped plan and sponsor a statewide youth leadership event entitled Lead On!

Activities continued in census areas of the state where rates of births to teens and single women were higher than the state average. Reproductive health educational materials and some long-acting reversible contraceptives were provided at no cost to teens and women of all ages in over 46 Alaskan communities, most of these in remote locations. Skills-based trainings, including hands-on, audio conference, self-study and web-based, were offered throughout the year. Informal surveys of rural health workers were conducted in order to learn perceptions about teens' needs for reproductive health care services. Limited access to comprehensive reproductive health services and high cost of effective contraceptives continued to be the leading concerns.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide funding for nurse practitioners to offer comprehensive reproductive health services at the Kodiak PHC and Juneau High School Teen Health Center. | X | | | X |
| 2. Maintain cervical cytology laboratory contract for all State of Alaska PHCs. | X | | | X |
| 3. Form and administer youth advisory committee focused on pregnancy prevention and violence prevention. | X | | | X |
| 4. Provide fiscal, administrative and clinical oversight to two Title X Family Planning clinics. | X | | | X |
| 5. Offer professional educational opportunities on topics relevant to teen reproductive health for health care workers from areas with the highest rates of births to teens. | | X | X | |
| 6. Provide workshops on teen-parent communication in train-the-trainer format. | | | X | |
| 7. Co-create, implement, monitor and evaluate a statewide dating violence prevention and youth leadership campaign entitled “Stand Up Speak Up.“ | | | | X |
| 8. Provide administrative and technical support to two community partners for Youth Development as a Teen Pregnancy Prevention Strategy grants. | | X | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Most FY09 projects are continuing during FY10. In addition to expansion of services to teens in Juneau during this period, the City and Borough of Juneau opened another school-based health center at an additional high school and is offering the same nurse practitioner services at the Juneau Teen Health Center. The PSAs and Needs Assessment have terminated.

A number of new activities began in FY10. The AHP is collaborating with non-profit and State agencies to launch the "Stand Up, Speak Up" campaign aimed at reducing unhealthy relationships in teens and increasing youth leadership throughout the state- both activities having shown correlations with teen pregnancies. It is participating in the adaptation of the Fourth R curriculum to make it appropriate for Alaska youth. The Fourth R is a Canadian curriculum which focuses on establishing healthy relationships as a way to reduce substance abuse, violence and teen pregnancy.

The AHP is initiating the Youth Alliance for a Healthier Alaska, an advisory committee comprised of all youth that advise the State on important matters relevant to teens, including teen pregnancy and violence prevention. It is also planning and implementing a Teen Pregnancy Mini Summit, to be attended by Alaska youth.

The Program is developing and implementing several statewide train-the-trainer trainings for teen-parent communication workshops. It is also presenting the results of the needs assessment at state and national conferences.

**c. Plan for the Coming Year**

In FY11, Title V will continue to fund nurse practitioners to provide comprehensive reproductive health services at the Kodiak PHC and the Juneau High School Teen Health Center. The City and Borough of Juneau plans to expand again and open a third school-based health center in FY11, where they also plan to employ a nurse practitioner to provide reproductive health services in this community.

Cervical cancer screening services will continue and remain available to women seeking family planning and related reproductive health services at State PHCs and, per USPSTF guidelines, at the Juneau school clinic. Women with abnormal screening results will continue to be referred to the Alaska Breast and Cervical Health Check program for diagnostics and/or treatment as needed.

The FPP will continue to administer the Title X Family Planning Services grant serving communities in the Mat-Su Valley and the lower Kenai Peninsula. As required by this federal program, FPP Title X services will continue to promote parental involvement in teen decisions to seek family planning services and to offer comprehensive sexuality education and counseling, including encouraging abstinence, as a core part of their service delivery.

Principals, teachers, teacher's aides, substitute workers, school nurses, and other interested school staff from alternative schools in Anchorage and the Mat Su Valley will be offered training on healthy adolescent relationships and communicating effectively with teens. These staff members are all mandatory reporters of sexual abuse of minors who spend at least six hours each day working with and around at-risk teens. Increasing the knowledge for adults who have so much contact with at-risk youth is a critical need.

All Adolescent Health FY 10 projects will continue in FY 11.

In addition, several teacher trainings will be held, where teachers will be trained in the implementation of the Fourth R curriculum. The AHP will also create a video aimed at reducing teen births among women in rural areas of the state and create materials to support the video, such as posters and wallet cards. The AHP will also design and coordinate train-the-trainer and

adolescent health trainings for youth, teachers, and other service providers on topics such a healthy sexuality, healthy relationships and parent-adolescent communication.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 26 | 26 | 26 | 55 | 55 |
| Annual Indicator | 17.5 | 52.4 | 52.4 | 55.4 | 55.4 |
| Numerator | 1414 | 1260 | 1260 | 457 | 457 |
| Denominator | 8082 | 2405 | 2405 | 825 | 825 |
| Data Source | | | | AK Oral Health Program, 2007 Oral Health Survey. | AK Oral Health Program, 2007 Oral Health Survey. |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 55 | 55 | 55 | 55 | 60 |

**Notes - 2009**
Data source: AK Oral Health Program, 2007 Oral Health Survey. Available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/2007_OralHealth_Children.pdf. The next survey is awaiting funding.

**Notes - 2008**
Data source: AK Oral Health Program, 2007 Oral Health Survey. This is survey data.

**Notes - 2007**
Source: 2004 Oral Health Survey, AK Oral Health Program.

/2008/ The data source has been changed. Previously we estimated this indicator from Medicaid records. We now use data from the AK Oral Health Survey - 2004 conducted by the AK Oral Health Program. Summary report available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/OHAssessment_0405.pdf

**a. Last Year's Accomplishments**
In state fiscal year 2007, the Oral Health Program (OHP) completed the second statewide dental assessment of third grade children using the "Basic Screening Survey" method. The dental assessment process included state baselines on dental sealants on at least one permanent first molar. The state baseline (2007) for sealant utilization in third-grade children was 55.3% (up from 52.4% in 2004); meeting the MCH Block Grant performance measure goal and Healthy People 2010 goal for dental sealant utilization. Sealant utilization for racial/ethnic groups and third-graders reported to be enrolled in Medicaid was as follows:

| | |
|---|---|
| Dental Sealants Present: Total (n=813) | 55.3% (51.9, 58.7) |
| American Indian/Alaska Native (n=130) | 67.7% (58.9, 75.6) |
| White (n=442) | 56.1% (51.3, 60.8) |
| All Other (n=241) | 50.2% (43.7, 56.7) |
| Asian (n=63) | 47.6% (34.9, 60.6) |
| Black/African American (n=23) | 56.5% (34.5, 76.8) |
| Hispanic/Latino (n=43) | 51.2% (35.5, 66.7) |
| Native Hawaiian/Pacific Islander (n=19) | 31.6% (12.6, 56.6) |
| Multi-racial (n=93) | 53.8% (43.1, 64.2) |
| Medicaid/Denali KidCare (n=222) | 57.2% (50.4, 63.8) |
| American Indian/Alaska Native (n=56) | 66.1% (52.2, 78.2) |
| White (n=76) | 53.9% (42.1, 65.5) |
| Other (n=90) | 54.4% (43.6, 65.0) |

Data has not been collected on the number of unduplicated Alaska children aged 8-9 with at least one dental sealant applied to a permanent molar paid for by Medicaid. Sealants not billed to Medicaid are not available; therefore the reported sealant utilization from Medicaid claims with past reports underestimates the sealant utilization in this population. Sealants for children reported as Medicaid eligible remained stable from 57.4% in 2004 (BSS data) to the above noted 57.2% in 2007 (BSS data). Past reports on sealants from Medicaid claims indicated the percentage of children with at least one dental sealant on at least one permanent molar for SFY1997 was 16.7%. For SFY2000-2007 it has varied from a low of 14.4% in SFY2004 to a high of 17.5% in SFY2005. The information from Medicaid claims clearly shows the underreporting from this method as compared with dental assessment information.

This past year the OHP worked with the dental association and University of Alaska to continue training on child abuse and neglect awareness and reporting requirements; worked with Medicaid for the reauthorization of adult dental preventive and enhanced restorative services (2009 legislative session); provided training on the "Cavity Free Kids" oral health curriculum to Head Start grantees, and prepared a white paper on the need for Medicaid reimbursement for fluoride varnish application by medical providers.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Support and promote community water fluoridation in all communities of Alaska. | | | | X |
| 2. Identify funding to support a statewide dental sealant coordinator. | | | X | |
| 3. Collaborate with 330 funded Community Health Centers to establish a dental sealant program. | | | X | |
| 4. Support coalition activities and the implementation of the comprehensive state oral health plan. | | | | X |
| 5. Collaborate with Tribal programs including Head Start and Environmental Health to support dental access, education, sealant application and water fluoridation. | | | | X |
| 6. Maintain program web site for dental access, oral health information and coalition activity. | | | | X |
| 7. Continued technical assistance on information to parents/providers on reducing risks of enamel fluorosis (while | | | X | |

| | | | | |
|---|---|---|---|---|
| still supporting water fluoridation to reduce dental decay). | | | | |
| 8. Maintain oral disease burden document describing oral diseases in Alaska and the impact of those diseases on the state. | | | | X |
| 9. Work with Commissioner's Office and Alaska Dental Action Committee for continued implementation of adult dental Medicaid services and report findings to the legislature. | | | | X |
| 10. | | | | |

**b. Current Activities**

The OHP conducted a school-based dental sealant pilot program with the Anchorage Neighborhood Health Center in February 2010 -- sealant retention checks and sealant placement will be done in a follow-up in February 2011. The program also is providing training on dental treatment for children with special health care needs in dental clinic settings in June 2010.

The Commissioner's Office directed Medicaid reimbursement coverage for medical providers for fluoride varnish and oral evaluation in January 2010. The OHP is working with Medicaid on implementation of the reimbursement for these services and providing links to web-based training for medical providers on these procedures. Planned implementation is for July 2010. The Alaska Dental Society is looking at sponsoring a web-based training for dentists, dental hygienists, physicians and nurses on early childhood caries prevention in the fall of 2010.

The OHP is working with the Head Start Collaboration Office and American Academy of Pediatric Dentistry (AAPD) on a dental home initiative for children enrolled in Head Start -- scheduled kick-off for the campaign is in the fall of 2010.

The Dental Officer and sealant coordinator continue to meet pediatric and Tribal dentists to encourage increased dental visits for children in Medicaid prior to 2 years of age in order to address the high levels of early childhood caries and related hospital-based dental treatment seen in Alaska.

**c. Plan for the Coming Year**

The OHP conducted a school-based dental sealant pilot program with the Anchorage Neighborhood Health Center in February 2010 -- sealant retention checks and sealant placement will be done in a follow-up in February 2011. The program also is providing training on dental treatment for children with special health care needs in dental clinic settings in June 2010.

The Commissioner's Office directed Medicaid reimbursement coverage for medical providers for fluoride varnish and oral evaluation in January 2010. The OHP is working with Medicaid on implementation of the reimbursement for these services and providing links to web-based training for medical providers on these procedures. Planned implementation is for July 2010. The Alaska Dental Society is looking at sponsoring a web-based training for dentists, dental hygienists, physicians and nurses on early childhood caries prevention in the fall of 2010.

The OHP is working with the Head Start Collaboration Office and American Academy of Pediatric Dentistry (AAPD) on a dental home initiative for children enrolled in Head Start -- scheduled kick-off for the campaign is in the fall of 2010.

The Dental Officer and sealant coordinator continue to meet pediatric and Tribal dentists to encourage increased dental visits for children in Medicaid prior to 2 years of age in order to address the high levels of early childhood caries and related hospital-based dental treatment seen in Alaska.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 5.6 | 5.6 | 5.6 | 4.5 | 4.5 |
| Annual Indicator | 6.5 | 5.0 | 4.1 | 3.9 | |
| Numerator | 31 | 24 | 20 | 19 | |
| Denominator | 480546 | 480464 | 482503 | 486703 | |
| Data Source | | | | AK Bureau of Vital Statistics | AK Bureau of Vital Statistics |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 4.5 | 4.5 | 4.5 | 4.5 | 4.5 |

**Notes - 2009**
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2006 - 2008. This indicator is reported by 3-year moving averages.

**Notes - 2008**
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2006 - 2008. This indicator is reported by 3-year moving averages.

**Notes - 2007**
Source: Alaska Bureau of Vital Statistics

**a. Last Year's Accomplishments**
The Section of Injury Prevention and Emergency Medical Services (IPEMS) provided a Child Passenger Safety (CPS) Educational Coordinator whose duties included support of the CPS instructor group. The coordinator provided support for each population center including Mat-Su, Anchorage, Kenai and Fairbanks.

IPEMS maintained a current, accurate database of certified CPS instructors and technicians, assisted with training and re-certification of new and experienced technicians, as well as provided 2 renewal courses for CPS technicians whose certification had expired. Over 50% of the CPS technicians completed recertification during the grant period. Each CPS technician received an injury prevention calendar with trainings and activities at least 8 times during the year and an updated CPS recall list at least 4 times a year. IPEMS developed and provided continuing education units (CEUs) that met national standards to qualify for re-certification. The CEUs included local training courses and web based/teleconferences statewide.

IPEMS assisted with correspondence and facilitated communication between the Safe Kids worldwide certification offices and Alaska CPS personnel for registration, recertification, and problems with auditing of records.

IPEMS supported the Alaska CPS Advisory Board (CPSAB) in implementation of statewide CPS activities and supervision of certification and recertification of CPS instructors and technicians. The CPSAB met 6 times during the fiscal year. IPEMS was the liaison between the CPSAB and the Section of Injury Prevention Emergency Medical Services (IPEMS).

The IPEMS resource lending library expanded inventory of child restraints and training materials for children with special needs. In partnership with the National Health, Transportation and Safety Administration (NHTSA), a course on "Safe Travel for All Children" was offered. The course provided instruction for staff on transporting special needs children with the appropriate child restraints. The lead instructor was Marilyn Bull, the leading pediatrician in this field.

IPEMS submitted requests for the procurement of bicycle, ATV/snow-gos and pedestrian training supplies and maintained records and disbursement logs of the supplies sent to bicycle, ATV/snow-go and pedestrian programs. Resources on safe use of bicycles, ATV/snow-gos and pedestrian practices for injury prevention were maintained and improved on the website. Injury prevention personnel were able to access resource lists of programs available throughout the state.

IPEMS acted as an advocate for local and statewide laws, regulations, and policies that sustain and increase the correct and safe use of bicycles, ATVs/snow-gos and pedestrian practices. Emphasis on educational support to the Booster Seat Coalition was given in effort to pass clarifying language on the use of booster seats for children smaller that 5'7" and less than 8 years of age. In FY 2009, Chronic Disease Prevention and Health Promotion (CDP&HP) provided education in support of legislative action to clearly include booster age children. CDP&HP was a coordinator/educator for the Booster Seat Coalition. The statute passed the Alaska Legislature and was signed into law. Alaska is now in compliance with NHTSA requirements for child restraint use. CDP&HP participated in child seat and booster distribution programs throughout the state.

The Section supported Safe Kids and Fed Ex in the National Walk to School project. CDP&HP continued to provide reflective materials, to educate on "See and Be Seen", and worked with bike rodeos and helmet distribution programs.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Help lead the “Booster Seat Coalition” to implement the booster seat legislation is education and distribution of booster to underserved populations. | | | | X |
| 2. Support trained firefighters to conduct CSP inspections at each Anchorage Fire Department and Kenai Fire Department. | | | X | X |
| 3. Conduct CPS introduction and technician courses. | | | | X |
| 4. Conduct renewal and recertification courses for CPS technicians. | | | | X |
| 5. Implement the revised the “Safe Native American Program (SNAP) for CPS” standards. | | | | X |
| 6. Update and secure national approval for a CEU web-based course. | | | X | |
| 7. Provide boosters, child restraints, and training materials. | | | X | |
| 8. Conduct bicycle rodeo and helmet fitting. | | | X | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The Section supports the Alaska CPS Board that provides oversight of CPS activities including at least two face-to-face meetings and three teleconferences.

CDP&HP provides CPS trainings and renewal courses and remains the CPS training provider and resource for state agencies such as Office of Children's Services. CEUs are provided for CPS technician recertification. The trainings and injury prevention activities are distributed via email and web-based calendar. CDP&HP maintains and distributes training supplies, child restraints, and presents at in-state conferences and workshops.

CDP&HP continues to strengthen our CPS technician cadre by retaining and increasing the number of CPS technicians. We hope to again retain over 58% of our present CPS technicians. CDP&HP provides CEUs for CPS technician recertification.

CDP&HP continues work to prevent TBI by evaluating and refining our programs for non-traditional motor vehicle transportation, such as snow machines and ATVs. CDP&HP is expanding our state website to increase our materials on the prevention of TBI.

CDP&HP supports local injury prevention activities such the Bear Paw festival bike rodeo and the Bicycle Summit, including "Safe Routes to School" and "Walk to School" programs and school bus activities within the state.

In response to the new booster seat legislation, we provide community and law enforcement education and distribution of booster seats and child restraints to underserved communities statewide.

**c. Plan for the Coming Year**
CDP&HP will provide a CPS Educational Coordinator who will support CPS activities statewide. Duties will include supporting the CPS instructor group with at least one certified CPS instructor per major population center, assisting with the training and recertification of CPS technicians, maintaining an up to date and accurate database of instructors and technicians, and providing renewal courses for CPS technicians whose certification has expired.

The Coordinator will be responsible for developing a statewide CPS plan. Each CPS technician will receive an injury prevention calendar with trainings and activities at least 8 times per year. CPS programs will distribute at least 40 boosters and child safety seats as part of their trainings to underserved populations. At least 4 short term introductions to CPS will be presented in non urban settings in the state. A short introduction to CPS for law enforcement appropriate for Alaska will be developed and implemented in the state. Section representatives will meet at least two times with court system officers to develop a diversion program for CPS offenders.

Continued activities will include expanding the resource lending library of child restraints and training materials for children with special needs. If sufficient support, the Coordinator will co-sponsor the NHTSA "Safe Travel for All Children" course to train staff in transporting children with special needs in the appropriate child restraints.

The Coordinator will assist with correspondence and facilitate communication between Safe Kids Worldwide certification offices and Alaska CPS personnel.

The Coordinator will support the Alaska CPSAB activities and function as a liaison between the Board and CDP&HP, assuring the Board implements CPS activities statewide and oversees certification and recertification of CPS instructors and technicians.

The website, available to the public and prevention specialists, will be maintained and improved

as a training resource for safe use of bicycle, ATV/snow-gos and pedestrian practices. Resource lists will be maintained for prevention personnel. Distribution of reflectors or reflective materials will be provided to pedestrian programs and children in underserved communities.

CDP&HP will advocate for local and statewide laws, regulations, and policies that sustain and increase the correct and safe use of bicycles, ATV/snow-gos and pedestrian practices to reduce injury to children in motor vehicle incidents.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 60 | 60 | 65 | 65 |
| Annual Indicator | 52.2 | 14.8 | 59 | 53 | 57.1 |
| Numerator | 266 | 1565 | | | |
| Denominator | 510 | 10605 | | | |
| Data Source | | | | CDC National Immunization Program | CDC National Immunization Program |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 65 | 70 | 70 | 70 | 70 |

**Notes - 2009**
Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services available at http://www.cdc.gov/breastfeeding/data/NIS_data/2007/state_any.htm.

This rate is for children born in 2007.

**Notes - 2008**
/2010/ Source: 2007 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Accessed 3/16/2009 from http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm.

Data is given by child's birth cohort. The latest available data is for children born in 2005, collected from interviews conducted in 2007. Data for the 2005 cohort is provisional, to be updated in 2010. Data for the 2004 cohort is updated.

**Notes - 2007**
2009/ Source: 2006 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Data is now given by year of birth of the children as

opposed to percentage of respondents by year of respondent interview. The latest available data is for children born in 2004, collected from interviews conducted through December 2006. Data for 2004 is provisional, additional updates to 2004 data will be made by NIS in late 2008. For children born in 2004, some of the survey questions changed.

/2010/ 4. Source: 2007 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Accessed 3/16/2009 from http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm. Data is given by child's birth cohort. The latest available data is for children born in 2005, collected from interviews conducted in 2007. Data for the 2005 cohort is provisional, to be updated in 2010. Data for the 2004 cohort is updated.

**a. Last Year's Accomplishments**

WIC received $78,545 to continue the Using Loving Support Breastfeeding Peer Counseling Program (BPCP). This program is administered by the Anchorage WIC Programs, Municipality of Anchorage and the Cook Inlet Tribal Council.

Breast pump loan programs continue to support WIC clients when a documented need for a breast pump exists. Breast pumps range from manual hand pumps, single user electric and multiple user electric pumps to meet the individual needs of the mothers expressing breast milk.

The State WIC program staff participated on the Alaska Association of WIC Coordinators Breastfeeding The State WIC breastfeeding coordinator attended a train-the-trainer program on the Business Case for Breastfeeding (BCFB). The training curriculum is intended to assist health care professionals with implementing breastfeeding support in the workplace in their communities.

Alaska WIC collected data and monitored trends through the Alaska PRAMS and Alaska WIC Management Information System. Alaska WIC's breastfeeding duration at 6 months decreased to 46% from the year's previous rate of 51%.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maintain the Using Loving Support Breastfeeding Peer Counseling Program. | | | X | X |
| 2. Sustain the WIC breast pump loan program and support services for breastfeeding women. | | X | | |
| 3. Support the Alaska Association of WIC Coordinators Breastfeeding Committee and state agency collaborations. | | | | X |
| 4. Continue active participation with the Alaska Breastfeeding Coalition. | | | | X |
| 5. Continue data collection and monitoring through PRAMS and Alaska WIC Management Information System. | | | | X |
| 6. Work with partners to plan activities to recognize World Breastfeeding Week in October 2010. | | | | X |
| 7. WCFH perinatal nurse consultant to provide consultation on breastfeeding issues. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The BPCP and breast pump loan activities from last year continue.

The University of Alaska Anchorage training program facilitates a breastfeeding list serve for breastfeeding peer counselors, supports the Using Loving Support BPCP as an on-line training, and publishes a monthly newsletter on breastfeeding, which includes a continuing education component. The university training program provided Loving Support "Grow and Glow" training to WIC staff this past year.

WIC staff from across the state participated in the annual Alaska Breastfeeding Coalition (ABC) conference this spring. The State WIC breastfeeding coordinator continues to work with ABC on the BCFB initiatives, including moving forward on a Department of Health and Social Services breastfeeding policy with assistance from the WCFH perinatal nurse consultant, and working with a Juneau-based group to move forward on the BCFB initiatives.

For the first time in 30 years, the WIC food package changed to better meet the needs of participants, and WIC has implemented sweeping changes to breastfeeding policies and breastfeeding support at the local level.

The State WIC program staff continues to participate on the Alaska Association of WIC Coordinators Breastfeeding Committee and collaborate with the ABC. Alaska WIC continues to collect data and monitor.

**c. Plan for the Coming Year**

Next year the WIC Program will continue current year activities to support and promote breastfeeding. Our goal is to maintain initiation and duration rates at 6 and 12 months. Additional training at the local WIC agency level will help support staff in their breastfeeding knowledge. More single-user-only pumps will be available statewide to support mothers as they return to work and school. WIC is interested in developing a State of Alaska breastfeeding workplace policy to support mothers returning to work and maintaining a milk supply.

Alaska has received additional bonus breastfeeding funds for the year and is in the process determining how best to use the funding. The plan at this time is to provide additional staff breastfeeding training, collaborate with the ABC to help implement the BCFB in our state and purchase breastfeeding resources for health care providers.

The WCFH perinatal nurse consultant will continue to provide consultation and testify for the legislature, when requested. The perinatal nurse consultant expects to conduct an update, revision, printing and distribution of the Healthy Mother, Healthy Baby Diaries, which will include updated breastfeeding information.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 92 | 94 | 96 | 98 | 100 |
| Annual Indicator | 90.5 | 91.8 | 92.5 | 94.6 | 96.7 |
| Numerator | 9351 | 9978 | 10092 | 10525 | 10211 |
| Denominator | 10327 | 10865 | 10916 | 11120 | 10555 |
| Data Source | | | | AK Newborn | AK Early Hearing |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Hearing Screening Program | and Detection Intervention Progr |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2009**
/2011/ There is a data discrepancy for Elemendorf Air Force Base hospital. Without Elmendorf, the hospital screening rate is 98%. Total screening rate for all births is 94%, not including Elemendorf.

**Notes - 2008**
62 infants were not available for screening for one of the following reasons: parental refusal, parental non-response, moved out of state, infant deceased. They were not included in the denominator.

Steady increases are occurring thanks to the active support by the direct entry midwife community in referring families for screening. Hearing screening equipment is availabe in the communites where the majority of home births or birthing center births occurr. Intensive follow up of these families through registered mail and follow up phone calls has also resulted in some families seeking hearing screening for their newborns.

**Notes - 2007**
Data Source: AK Bureau of Vital Statistics, AK Newborn Hearing Screening Program

**a. Last Year's Accomplishments**
Last year's focus was to increase the number of children tracked successfully through the National 1-3-6 Goals and reduce the number of children lost to follow-up/documentation.

The Early Hearing and Detection Initiative (EHDI) Program continued to send monthly fax reports to birthing facilities to improve follow-up. Letters were sent to parents who had a missed or failed screening and certified letters were sent to the infant's medical home. The program utilized the database to identify which children were not returning for follow-up. Outcome of the queries indicated the greatest lost to follow-up after a failed newborn hearing screening occurred when children were discharged from hub facilities to remote communities not accessible on the road system. Another population of children identified was those born on the Air Force Base. The latter may be an issue of documentation, reporting follow-up screens into the database. Remedies for these concerns will be addressed in the next year's activities.

The program worked with pediatric audiology to improve monthly entry of diagnostic data by audiologists as required by the EHDI mandate and facilitate timely access to intervention services. The EHDI Program worked with OZ Systems on the audiology upgrades for the database which were in development.

A process was established to receive a monthly list from the Bureau of Vital Statistics (BVS) of children born out of hospital whose parents applied for an Alaskan birth certificate. The list is

checked against the database and certified letters are sent to all parents of children who are not identified as having a newborn hearing screening. In CY 2008 35 % of infants born out of hospital received hearing screenings as newborns.

The EHDI Program had ongoing meetings with SOA Early Intervention(Part C) / infant learning program (EI/ILP) to implement a process for receiving named data of children with hearing loss enrolled in intervention services. An update on EI/ILP programs was presented to the EHDI Advisory Committee. The Diagnosis to Intervention Committee met to review the system for referrals to early intervention and continued to look at opportunities for improving this process. A separate EI/ILP section of the database was proposed. When implemented, it will electronically notify the State EHDI Program and State EI/ILP that a referral was made to early intervention. In addition, access to an immediate referral form to EI/ILP is planned.

The EHDI communication protocol was updated and finalized by the advisory committee; the committee continued to meet three times a year. The AAP- EHDI Chapter Champion presented at Pediatric Grand Rounds and highlighted the role of the medical home. The EHDI program manager co-presented and gave an update on the current status of EHDI in Alaska. The integration of the EHDI database with Newborn Metabolic Screening (NBMS) provided additional information on the infant's primary care provider.

A team attended the Investing in Family Support Conference in October 2008. A committee of parents continued to meet to address options for providing support to parents of young children with hearing impairments. A parent questionnaire, to be administered by the EHDI Program manager, was drafted. The EHDI Family Issues Committee participated in drafting the questionnaire. A Stone Soup Group (SSG) parent navigator, with previous EHDI experience took over this position in January 2009. Contact with parents of children who are deaf/hard of hearing was re-established, as well as networking with Early Intervention/Infant Learning Programs (EI/ILP) to provide family support to families of identified children.

The EHDI Program continued to seek opportunities for collaborating with Early Head Start (EHS) Programs with a focus on children at risk for hearing loss. Two Otoacoustic Emissions (OAE) screeners were loaned to the Parents as Teachers Program, which serves Anchorage and rural communities and another is on loan to the EHS program at Fairbanks Native Association. The EHDI Program continued to explore options for placing OAE screening equipment in remote regions of the state.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Assure accurate and complete utilization of the internet based reporting system through ongoing monitoring of data entry and training of new hospital staff, public health nurses, audiologist, early intervention staff and parent navigators. | | | | X |
| 2. Utilize a fax back system with birth screeners to track infants in need of follow-up. | | | | X |
| 3. Facilitate meetings of the Diagnosis to Intervention subcommittee to improve the process from diagnosis to intervention services for newly diagnosed children. | | | | X |
| 4. Contact parents of infants born out of hospital regarding importance of newborn hearing screening and provide focused education to midwifery centers. | | | X | |
| 5. Monitor the data entry by the audiology community in reporting diagnostic information in the database. | | | | X |

| | | | | |
|---|---|---|---|---|
| 6. Partner with the Stone Soup Group parent navigators to provide parent-to-parent support and resource information for families of children who are deaf or hard of hearing. | | X | | |
| 7. Collaborate with the Early Intervention/Infant Learning Program to develop a system for identifying and tracking children with hearing loss. | | | X | |
| 8. Communicate with outlier communities with implemented UNHS and assure adherence to EHDI protocol and linkages to EI, medical home and audiology. | | | X | |
| 9. Partner with AAP Chapter Champion on EHDI presentations to primary care providers. | | | | X |
| 10. Monitor the database for quality assurance and follow-up for children who refer on screening or are diagnosed with hearing loss. | | | | X |

**b. Current Activities**
Emphasis this year is to increase the State's success in meeting the National 1-3-6 Goals and improve services and supports to young children with hearing loss and their families.

The Alaska EHDI Program prepared and distributed a report to the Governor, key legislators and stakeholders on the first year of Alaska's newborn hearing screening mandate. The report states approximately 98% of infants born in hospitals in 2008 were screened and 95% of all occurent births in Alaska, which includes out of hospital births, were screened. Ninety-seven percent of all infants passing screening were screened before one month of age.

The EHDI Program is analyzing the data on infants born out of hospitals to determine which birthing centers/midwives require more education.

The EHDI Program is communicating through meetings and email with the Air Force base to solve loss to documentation issues.

The audiology section of the EHDI database is updated and a training Webex to familiarize audiologist with the changes is scheduled. The parent survey was developed and mailed to parents whose children were born in 2008. Due to the poor return rate, the EHDI Program Manager will contact parents by telephone. The SSG parent navigator established a Lending Library.

The AAP Chapter Champion, presented at Grand Rounds with an audiologist to review the role of the medical home in supporting children diagnosed deaf/hard of hearing.

***An attachment is included in this section.***

**c. Plan for the Coming Year**
The EHDI program will continue to focus attention the national 1-3-6 goals by addressing children lost to follow-up after initial screening and ensuring children receive timely diagnostic and early intervention services.

The EHDI Program will continue to partner with EI/ILP to track children from diagnosis to intervention services. An EI/ILP section will be added to the EHDI database. This will assist both programs in tracking and identify where children are lost to follow-up. The database will be utilized to establish a named match between both programs. The programs will collaborate on opportunities for staff training for early interventionists working with children with hearing differences.

The EHDI Program will collaborate with regional hubs to operationalize and incentive program to

increase the number of follow-up screens for children residing in remote rural regions of the State. Parents who bring their children in for follow-up screenings will receive a gift card after their child has a follow-up screening. The state will track the change in follow-up for designated communities.

Hearing screening equipment will be purchased and placed in two communities with high numbers of out of hospital births and low rates of newborn hearing screening. The midwifery centers will be trained on the EHDI database and they will report screening results to the EHDI Program. The program will monitor the change in rate of infants born out of hospital that receive newborn hearing screenings.

The EHDI Program will continue to work with military facilities to improve tracking of infants from screening through diagnosis. This will include data reporting to the EHDI Program and entering missed data. The program will also work with the military to address the higher than expected rates of infants not passing newborn hearing screening.

Ongoing education and training on EHDI will be available on an as needed basis. Opportunities to engage the medical home will continue to be explored. The AAP Chapter Champion will participate in this endeavor. The EHDI Program Manager and the Newborn Metabolic Screening Manager will collaborate on a newsletter with updates, data and highlighting program improvements.

The Family Issues subcommittee will continue to meet and focus on avenues for improving parent support to parents of children diagnosed deaf or hard of hearing. Parent navigation will be available to parents of newly diagnosed children using funds granted by HRSA through the UNHS federal grant. The EHDI program will explore options for follow-up with parents who did not return the parent survey. It is proposed that a team will attend the 2010 Investing in Families Conference.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 14 | 10 | 9 | 8.5 | 8.5 |
| Annual Indicator | 9.2 | 9.4 | 11.2 | 13.2 | |
| Numerator | 17880 | 18108 | 21501 | 25600 | |
| Denominator | 195240 | 192234 | 192254 | 193600 | |
| Data Source | | | | Kaiser Family Foundation | Kaiser Family Foundation |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 8.5 | 8.5 | 8.5 | 8.5 | 8.5 |

**Notes - 2009**

2008 is the latest available data.

**Notes - 2008**
/2011/ Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2007-2008). Retrieved March 9, 2010 from http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi. Estimates (numerator and denominator) based on the Census Bureau's March 2008 and 2009 Current Population Surveys. Data covers children 0 - 18 years old. AK Dept. of Labor population estimates would put denominator at 208,084.

**Notes - 2007**
Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2006-2007). Retrieved March 16, 2009 from http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi.

Data covers children 0 - 18 years old. AK Dept. of Labor population estimates would put denominator at 205,460. Estimates (numerator and denominator) based on the Census Bureau's March 2007 and 2008 Current Population Surveys.

**a. Last Year's Accomplishments**
In FFY 09, 12-month continuous eligibility for children was implemented and the waiting period or anti-crowd-out provision was removed as the Denali KidCare 1115 waiver for children ended on September 30, 2009. Children in families with incomes of greater than or equal to 151% FPG or above who have stopped or cancelled coverage within the prior 12-month period no longer are required to wait for one year without health insurance coverage before they may become eligible for Denali KidCare.

Efforts to raise the eligibility level of 200% of FPL were introduced in the form of 5 different bills in the State of Alaska legislature. None of them moved through both houses prior to the end of the legislative session.

The Title V program was very active in promoting the tenets of the Assuring Better Child Development (ABCD) screening program and worked in collaboration with the Early Childhood Comprehensive Systems (ECCS) program (also located in another division). A joint application for the ABCD III grant was submitted in support of implementing consistent developmental testing with EPSDT exams.

Title V dollars continued to provide gap-filling services in the area of pediatric specialties including genetics and metabolic clinics, neurodevelopmental/autism screening services, cleft lip and palate assessment and evaluation, and parent navigation. Reproductive health services for young women and teens were provided using Title V dollars for contraceptive purchases and tests for cervical screening as well as payment for contracted ANP services.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The AK Title V staff will collaborate with Rural Health, Medicaid, Public Health Nursing and the Commissioner's office to improve outreach, enrollment, and participation of providers for EPSDT screenings. | | | | X |
| 2. Respond to requests for information related to Denali KidCare legislation. | | | | X |
| 3. Participate with Regional Tribal Health Centers to conduct administrative activities to ensure efficient and effective | | | | X |

| | | | | |
|---|---|---|---|---|
| administration of the Medicaid enrollment program. | | | | |
| 4. Work with advocacy groups to encourage action on the part of the legislature to raise the eligibility level for SCHIP to 200% of FPG. | | | | X |
| 5. Title V staff will continue to participate in the redesign and implementation of the new Medicaid Management Information System to assure capacity, data collection, and activities support an EPSDT utilization analysis. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The first major accomplishment in FFY 10 was the receipt of the Children's Health Insurance Program Reauthorization Act (CHIPRA) performance bonus payment for increasing enrollment of low-income children into Medicaid and Denali KidCare and meeting 5 of 8 eligibility and enrollment simplifications as specified under CHIPRA. Only 9 states including Alaska received this performance bonus payment in 2010 for the FFY 09.

Two, Alaska won one of the CHIPRA grant awards for quality improvement for children. AK, OR, & WV will collaborate under the Tri-state Children's Health Improvement Collaborative and received $11,000,000 over five years. The grant will demonstrate the combined impact of patient-centered care delivery models and health information technology on the quality of children's healthcare. The goal of the grant is to demonstrate that the quality of children's health care can be improved by using health information technology.

Title V dollars will continue to provide gap-filling services in the area of pediatric specialties as outreach clinics in genetics, metabolic, neurodevelopmental, and CL/P. Reproductive health services for young women and teens covering contraceptives, cervical screening testing, and ANP contracts for direct services at Public health centers are also provided using Title V dollars.

There were five bills filed in 2009. In 2010, Denali KidCare passed in mid-April to increase the FPGs to 200%. The governor vetoed the bill.

**c. Plan for the Coming Year**

Next year, 2011, it is hoped that the Department will again receive a CHIPRA performance bonus payment.

After the initial planning phase for the grant is accomplished in early FFY 2011, the CHIPRA quality improvement Alaskan grant team within the Department grant will begin working with its state partners to improve the quality of children's health care through children's quality measurement, to enhance care coordination and to evaluate patient centered medical homes through the use of health information technology and health information exchange in Alaska.

CHIPRA allotment funding will be rebased for the first time in 2011, and it is hoped that child outreach was supported enough to increase enrollment and corresponding child health expenditures in 2010 so the CHIP allotment will not be adversely impacted and lowered for 2011 and 2012 since rebasing under CHIPRA is directly linked to FFY 2010 child health expenditures.

The MCH Title V/CSHCN Director will continue to focus attention this next year in working with the Medicaid program (located in the Division of Health Care Services) and assuring that both

programs are more effectively meeting the requirements for outreach and education around EPSDT services and Medicaid coverage. In addition, joint educational sessions will be developed for health care providers around the components of EPSDT and developmental screening in support of the special efforts underway as part of the ABCD program.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 22 | 21.5 | 21 | 20.5 |
| Annual Indicator | 22.1 | 21.7 | 21.6 | 21.5 | 21.7 |
| Numerator | 3787 | 3398 | 3371 | 3374 | 3571 |
| Denominator | 17128 | 15667 | 15579 | 15662 | 16462 |
| Data Source | | | | WIC program, Report #340. | WIC program, Report #340 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 20 | 20 | 20 | 20 | 20 |

**Notes - 2009**
2011/ Source: WIC program, Report #340. Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for caucasian children.

**Notes - 2008**
Source: WIC program, Report #340. Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for caucasian children.

**Notes - 2007**
Source: WIC program, Report #340.

Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for caucasian children.

**a. Last Year's Accomplishments**
Alaska WIC rates for overweight children increased from 21.571% to 21.691%. The indicator measured children 2-5 years of age at or above the 95 percentile. The Family Nutrition Programs

Strategic Plan
http://www.hss.state.ak.us/dpa/programs/nutri/downloads/200705_strategicreport.pdf
continued to address obesity prevention in WIC grantees Requests for Proposals.

Sixteen Alaska WIC local agency (LA) grantees continued to include the goal to "reduce the prevalence of overweight and obesity among Alaskan children and adolescents," in their Nutrition Education and Services Plans. They continued implementing Alaska WIC's Nutrition Themes: "Family Meals and Breastfeeding…So Good For Me," "Playtime…. So Good For Me" and "Water, Water… So Good for Me!". Nutrition Education WIC funds were used to provide nutrition theme materials to local agencies. They are available on the Division of Public Assistance, Family Nutrition Programs, WIC, Nutrition Education website http://www.hss.state.ak.us/dpa/programs/nutri/WIC/WICEducation.htm. Dissemination of the nutrition themes continued via the State Nutrition Action Plan (SNAP) committee.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Implement new food WIC packages. | | X | | |
| 2. Implement value enhanced nutrition assessment. | | | X | |
| 3. Implement participant-centered education model training. | | | | X |
| 4. Use WIC nutrition reports for quality assurance/ program planning. | | | | |
| 5. Identify coordinated objectives to promote healthy eating and active lifestyles. | | | | X |
| 6. Disseminate nutrition themes via State Nutrition Action Plan (SNAP). | | | X | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Three major accomplishments have been achieved in 2010. They are the implementation of the WIC New Food Packages (NFP), the full implementation of Value Enhanced Nutrition Assessment (VENA) and the training on the Participant Centered Education (PCE) Model. WIC clients are receiving NFP including fruits and vegetables, fresh, frozen or canned; soy milk and tofu as milk alternatives; whole grains such as cereals and breads. The NFP provide less milk, eggs, and juice. These changes are helping WIC families eat more nutritious meals.

Alaska WIC is training staff on the PCE Model. It is a promising approach to help individuals develop positive nutrition and health related behaviors. WIC continues to implement and use Alaska WIC nutrition reports for quality assurance and program planning and identify coordinated objectives to promote healthy eating and active lifestyles.

WIC's Strategic Plan was revised and the new core purpose is: "quality nutrition education and food." The long term goal is: "no increase in % of obese WIC kids."

**c. Plan for the Coming Year**
Next year Alaska WIC local agency grantees will continue to include the goal to "reduce the prevalence of overweight and obesity among Alaskan children and adolescents" in their nutrition education and services plans. LA grantees will continue to incorporate all nutrition themes and

the revised WIC strategic plan in providing their clients' counseling and education.

The current WIC computer system is slated for replacement July 2011. The new system will continue to capture data on obesity and will lend itself to more flexible reporting functionality. This change will assist the Alaska WIC program in planning and assessing efforts to address obesity in our state. This coming year the program will focus on hiring a contractor who will transfer a new WIC computer system while making changes to the program to meet Alaska's needs. Complete implementation will be in October 2011.

These activities are infrastructure building, population-based, enabling, and direct health care services.

Data Source: Alaska WIC Program. WIC Report #340: Overweight Children Rates 1/1/2009 to 12/31/ 2009
Numerator = 3571; Denominator = 16462; Annual Indicator = 21.69%

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 15 | 15 | 13.5 | 13.5 |
| Annual Indicator | 16.7 | 14.8 | 15.5 | 15.0 | |
| Numerator | 1602 | 1565 | 1645 | 1637 | |
| Denominator | 9581 | 10605 | 10613 | 10879 | |
| Data Source | | | | Alaska PRAMS | Alaska PRAMS |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 13.5 | 13.5 | 15 | 15 | 15 |

**Notes - 2009**
Source: Alaska PRAMS

The latest data available is for CY 2008.

**Notes - 2008**
Source: Alaska PRAMS

The latest data available is for CY 2008.

**Notes - 2007**
Source: Alaska PRAMS

The latest data available is for CY 2007.

**a. Last Year's Accomplishments**
The perinatal nurse consultant continued to meet with private health care providers and administrators at facilities across Alaska. She visited the bush town of Dillingham and observed the provision of group prenatal care via teleconference. The perinatal advisory committee met twice, one meeting featuring a presentation about tobacco cessation efforts in Alaska, including the Alaska Quit Line. WCFH convened a preconception committee that met regularly. Tobacco cessation was a topic of consideration.

The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care (including the effects of tobacco), and tobacco cessation booklets furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

The consultant carried on activities that educated health care providers about the importance of early prenatal care. The perinatal list serve and distribution of printed materials continued, sharing information about evidence-based programs and professional education opportunities, including those related to tobacco. The WCFH Epi Section continued to conduct outcome data analyses and update MCH publications, including data related to tobacco.

The perinatal nurse consultant convened a steering committee, including a Healthy Native Babies consultant, and launched an infant safe sleep initiative. The role of tobacco was to be an important aspect.

The tobacco program hired a cessation grant manager and she and the perinatal nurse consultant started making plans to collaborate on development and distribution of some materials.

Free and Clear, for the third and final year of their contract, provided Alaska Quit Line services. In addition to a more intensive follow-up for pregnant smokers, they began developing protocols specific for pregnant callers. Additional training in quit coach college was provided to enhance counseling pregnant women. The perinatal nurse consultant will continue to support the Quit Line through education and referral efforts.

The tobacco program continued to participate on the Medicaid workgroup of the Alaska Tobacco Control Alliance to support the provision of cessation services. They worked to implement greater availability of treatment strategies, including reimbursement for pharmacists.

The Section of WCFH continued to investigate ways to support high risk mothers in Alaska, since public health nursing home visits are no long available in the Anchorage area, except to clients eligible for Alaska Native health services. Coming up with an affordable, effective home visiting program continued to be of interest, including integration of tobacco and other substance cessation interventions.

In 2008, 15.1% of women reported smoking in the last three months of pregnancy, showing a small decrease from the prior year and representing a general downward trend.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. WCFH and state tobacco program collaborate on projects related to tobacco cessation education for pregnant women and their health care providers. | | | | X |
| 2. Address the role of tobacco in infant sleep-related deaths via | | | | X |

| | | | | |
|---|---|---|---|---|
| the infant safe sleep project. | | | | |
| 3. Provide expanded and specialized Alaska Quit Line services for pregnant women, by adding Alaska-specific training. | | | | X |
| 4. Participate in the Alaska Tobacco Control Alliance Medicaid workgroup to advocate for improved coverage for tobacco cessation services. | | | | X |
| 5. Conduct MCH conference to include role of tobacco on the health of MCH populations. | | | | X |
| 6. Collaborate with Tobacco Program on an analysis of PRAMS data. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

General activities from last year have continued. The perinatal advisory committee met in November 2009. The perinatal nurse consultant distributes tobacco cessation booklets to providers of health care. The consultant supports March of Dimes through membership on the program services committee, and supports other agencies and individuals, as possible. She played an active role in the preconception committee, in which tobacco was an important topic, until the committee was suspended in January 2010.

The Tobacco Program and MCH Epi Unit are collaborating on an analysis of PRAMS tobacco data. Their publications, along with previously mentioned materials, are distributed via personal delivery, mail, and electronically.

The infant safe sleep initiative and role of tobacco is a major focus. WCFH and Alaska Native Tribal Health Consortium have planned a 3-day MCH conference in September 2010 that will address tobacco, among other topics.

The tobacco program and WCFH are collaborating on distributing materials. The Free and Clear contract to provide Alaska Quit Line services was renewed and has added Alaska-specific training related to chew tobacco, including iqmik. The consultant supports the Quit Line through education and referral efforts.

The tobacco program works through ATCA to advocate for increased Medicaid reimbursement for provision of tobacco cessation services, recently gaining reimbursement for pharmacists to conduct brief tobacco cessation interventions.

**c. Plan for the Coming Year**

The perinatal nurse consultant will continue activities from the prior year. She will continue to work with the tobacco control program on material development and distribution. Also, the consultant will explore the idea of working with the tobacco program to develop a rack card to promote the Alaska Quit Line's pregnant caller services.

A major focus of the coming year is completion of the grant process for the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting Program, conducting the needs assessment, and, presumably, beginning of program implementation. Tobacco cessation services will be included.

Other possibilities include: renewing efforts to reprint the popular Alaska Native tobacco cessation booklet (copyright concerns have delayed that work); exploring the American Academy of Family

Physicians' resources for tobacco cessation materials for health care providers and options for partnering with other health care provider groups, e.g. family medicine physicians and public health nurses to provide cessation education; and, working with ATCA on a PSA addressing pregnant women and tobacco.

Funds that were to go to a minigrant program instead will be used for the Alaska Infant Safe Sleep Initiative, part of which will address the role of tobacco in infant death.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 30 | 30 | 30 | 27 | 27 |
| Annual Indicator | 32.6 | 28.5 | 22.9 | 26.5 | |
| Numerator | 53 | 47 | 38 | 44 | |
| Denominator | 162555 | 164729 | 166142 | 166110 | |
| Data Source | | | | Alaska Bureau of Vital Statistics | Alaska Bureau of Vital StatisticsAlaska Bureau of |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 27 | 27 | 27 | 27 | 27 |

**Notes - 2009**
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2006 - 2008. This indicator is reported by 3-year moving averages.

**Notes - 2008**
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2006 - 2008. This indicator is reported by 3-year moving averages.

**Notes - 2007**
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2005 - 2007. This indicator is reported by 3-year moving averages.

**a. Last Year's Accomplishments**
In FY09, the Department's Comprehensive Behavioral Health Prevention & Early Intervention Services program was reintroduced and awarded funds for another three years. Fifty grantees

were awarded including sixteen community-based suicide prevention grantees funded throughout Alaska. Grantees employed prevention strategies that were designed to create a long-term impact in reducing the harmful effects of drugs and alcohol, increase resiliency and community wellness, and reducing suicide.

Grantee organizations ran a variety of youth, adult, community prevention and early intervention programs. Examples include healthy recreation programs, teen centers, sports activities, mentoring and cultural activities (i.e. subsistence, beading, carving, drumming and Alaska Native and Eskimo dance). Grantees are required to employ strategic prevention planning methods with support and technical assistance from the Alaska Division of Behavioral Health (DBH) to build sustainable and culturally competent practices and evidence-based prevention strategies. Project and program coordinators were situated within these communities/regions.

Accomplishments for FY09 continued to emphasize integrating suicide prevention programs with other behavioral health prevention strategies, activities and services. This was an ongoing effort that takes into account that for prevention projects and services to be effective, they also must be comprehensive and community-based.

The DBH was in its second year of the Substance Abuse and Mental Health Services Administration (SAMHSA) Garett Lee Smith Memorial Act Youth Suicide Prevention Grant. The Alaska Youth Suicide Prevention Project developed and awarded three regional suicide prevention teams. These regional teams were located in: 1) Fairbanks region, 2) urban and rural communities throughout Southeast Alaska and 3) the Lower Kuskokwim villages of Akiak, Akiachak, Kwethluk and Tuluksak. Strategic plans were developed for each region to incorporate early prevention, intervention and post-intervention strategies to reduce suicide among youth ages 15-24 years of age. A requirement of this grant is to provide the Alaska Gatekeeper Suicide Prevention Training to the regions.

The DBH completed its FY09 rural suicide prevention planning grant project. This was implemented in rural regions of the state with significantly higher rates of suicide as compared to the general population. This was a one-time appropriation from the legislature awarded to four communities. Each received approximately $45,000 to develop strategic regional suicide prevention plans. These regional plans were put in place and will be useful in tailoring comprehensive prevention strategies and drawing on local, regional, state and possibly federal resources. Based on this effort, Akiachak and partnering Lower Kuskokwim villages were awarded the Alaska Youth Suicide Prevention Grant.

The DBH continued to develop and expand the delivery of the Alaska Gatekeeper Suicide Prevention Training curriculum. The Summer Gatekeeper Institute was held in July 2009 and was instrumental in offering the training model to 11 new instructors. It also provided continuing education and support to former trainers, including refresher training, and introduced a new youth module.

The Suicide Prevention Council also worked closely with DBH and grantee communities to assist in promoting the Alaska Suicide Prevention Plan goals and objectives. A strategic planning meeting was held in April 2009 which renewed efforts in expanding the role of the Council and its partnership with DBH. These efforts included stronger coordination among State and tribal health systems, support for stronger early identification and screening programs in Alaska's schools, and broadened social marketing efforts to increase awareness of suicide prevention.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide for community-based suicide prevention grants. | | | | X |

| | | | | |
|---|---|---|---|---|
| 2. Develop a statewide mechanism for delivery of the Gatekeeper Suicide Prevention training curriculum. | | | X | X |
| 3. Develop a statewide mechanism for delivery of the Gatekeeper Suicide Prevention training curriculum. | | | X | X |
| 4. Promote the use of the evidence-based youth suicide prevention program, Signs of Suicide (SOS), peer helpers programs. | | | | X |
| 5. Participate and present at a number of statewide conferences. | | | | X |
| 6. Disseminate Alaska Suicide Prevention Plan and the Suicide Follow-Back Study. | | | | X |
| 7. Implement SAMHSA Alaska Youth Suicide Prevention Project (3-year grant project). | | | X | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The DBH is in its third year of the SAMHSA Garett Lee Smith Memorial Act Youth Suicide Prevention Grant. The grant is continuing its planning efforts in: 1) Fairbanks region, 2) communities throughout Southeast Alaska, and 3) Lower Kuskokwim villages. Strategic plans continue to be developed with some implementation beginning to occur. Many grantees are making changes to their emergency response and post intervention strategies, and media efforts to promote help lines and intervention services. Grantees are scheduling Alaska Gatekeeper Suicide Prevention Trainings.

The Department's Comprehensive Behavioral Health Prevention & Early Intervention Services program is in its second year of the three-year grant. Some programs have been increasing and enhancing services. Positive outcomes have been observed including the Alaska Careline crisis hotline which has shown an increase in call volume among youth. They have also implemented a website with chat capability which has shown an increase among youth utilizing the service. Some programs have been experiencing challenges, which has impacted their performance.

The DBH continues to develop and expand the delivery of the Alaska Gatekeeper Suicide Prevention Training curriculum. This year 15 new instructors were trained in the model. This has helped to increase the cadre of trainers throughout the state.

The Division continues to promote the Alaska Suicide Prevention Plan by disseminating the plan and the suicide follow-back study.

**c. Plan for the Coming Year**

Fiscal year 2011 will continue to see the development of the Alaska Youth Suicide Prevention Project, and third and final year of the Comprehensive, Behavioral Health, Prevention and Early Intervention Services grant program. Through these grant programs, the Department will be able to provide more infrastructure to the state's suicide prevention projects, and more individualized training and technical assistance to improve the community planning process and increase successful outcomes for suicide prevention grant programs. Community grantees will continue the use of community planning tools and the use of evidence-based and other best practice strategies that will ensure cultural responsiveness and longer term sustainability beyond grant funding.

The DBH will continue to expand and maintain the Alaska Gatekeeper Training curriculum by increasing the cadre of trainers. The Department will also continue to partner with University of Alaska Anchorage, Behavioral Health Research Services and Alaska Children's Services who

also train in the Gatekeeper model. Emphasis will be placed on capacity development in partnership with the Suicide Prevention Council to increase State and tribal health system coordination, and social marketing efforts to implement such evidence-based programs in schools and other youth organizations.

The Division will partner with the Alaska Native Tribal Health Consortium to expand these efforts among other tribal organizations and communities throughout the state. A formal review is also planned to determine the nature of rural grantees needs, challenges and resources for rural communities to apply for and receive support for their suicide prevention efforts.

The Division is also working on a statewide suicide prevention web-portal that will help to support stronger coordination among and between State, tribal, regional and community entities and other stakeholders. This web-portal will be implemented and released in July 2010.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 78 | 80 | 82 | 84 | 86 |
| Annual Indicator | 76.8 | 78.0 | 76.8 | 71.1 | |
| Numerator | 73 | 96 | 76 | 81 | |
| Denominator | 95 | 123 | 99 | 114 | |
| Data Source | | | | Alaska Bureau of Vital Statistics | Alaska Bureau of Vital Statistics |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 86 | 86 | 90 | 90 | 90 |

**Notes - 2009**
Source: AK Bureau of Vital Statistics. CY 2008 is most recent data available.

**Notes - 2008**
Source: AK Bureau of Vital Statistics. CY 2008 is most recent data available.

**Notes - 2007**
Source: Alaska Bureau of Vital Statistics

CY 2007is most recent data available.

**a. Last Year's Accomplishments**
The perinatal nurse consultant continued to meet with private health care providers and administrators at facilities across Alaska. She visited the bush town of Dillingham. The perinatal

advisory committee met twice. In February 2009, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) to conduct a conference featuring sessions on progesterone for preterm birth, obstetric emergencies, and STABLE. Also, WCFH participated in an MCH indicator project led by the city health department, which spotlighted low birthweight as one of only five indicators selected. The perinatal nurse consultant continued to support the program efforts of March of Dimes, whose national campaign is prematurity.

A number of activities address prenatal care generally. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth. The perinatal list serve, to share information about evidence-based programs and professional education opportunities, and distribution of other printed materials continued. The perinatal nurse consultant distributed the Hypertension in Pregnancy Resource Kit for Health Care Providers to birthing facilities across the state, in hopes of improving care of pregnant women with hypertension and encouraging timely transfer and transport. The WCFH Epi Unit continued to conduct outcome data analyses and update MCH publications.

There was a concern among some physicians that midwives are not always transferring the care of laboring women to higher level providers soon enough. Regulations and a clear complaint process are in place and midwives were contacted for their perspective. The perinatal nurse consultant is supporting the development of a perinatal nurse case manager position in Kotzebue.

In 2008 71.1% of low birthweight babies were born at The Children's Hospital at Providence, which has Alaska's only Level III NICU, down from76.8% in 2007. This falls far short of the 90% goal. Preterm birth data indicate that although medically indicated preterm birth increased in Alaska, among Alaska Natives the increase was met by a concurrent decrease in spontaneous preterm birth.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Explore concern regarding timely transfer and transport of laboring women who develop complications. | | | | X |
| 2. Convene perinatal advisory committee on a regular basis and spotlight key perinatal programs and issues, such as transfer/transport of neonates. | | | | X |
| 3. Plan and conduct joint MC conference in 2010, including topics related to low birth weight and appropriate transfer. | | | | X |
| 4. Support March of Dimes, whose national campaign is prematurity, counseling the state director and serving on the program services committee. | | | | X |
| 5. Conduct MCH outcome data analyses and update MCH publications, including the MCH Data Books. | | | | X |
| 6. Continue the perinatal list serve and distribution of printed materials, such as the Healthy Mother, Healthy Baby Diaries and Alaska MCH Data Books. | | | X | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Activities from last year have continued. The perinatal advisory committee met in November 2009. The perinatal nurse consultant continues to support March of Dimes through consultation with their new director of program services and membership on the program services committee, and supports other agencies and individuals, as possible. WCFH has continued to conduct outcome data analyses. These publications, along with previously mentioned materials, have been distributed via personal delivery, mail, and electronically.

Low birthweight was not addressed at a perinatal advisory committee, as planned, and some other planned activities were not conducted. Based on a review of state data, infant sleep-related death took precedence. The perinatal nurse consultant continues to monitor the issue of timely transfer/transport, offers support to midwives, and continues to distribute the Hypertension in Pregnancy Provider Kits.

WCFH and Alaska Native Tribal Health Consortium (ANTHC) are partnering to organize and conduct a 3-day MCH conference in September 2010 that will include topics relevant to prematurity and low birthweight such as prenatal alcohol and tobacco exposure and cessation, domestic violence, and stabilizing the pregnant women for transport.

The Section of WCFH has closely followed national health care reform legislation and is working to complete the first Affordable Care Act application to fund prenatal home visitation.

**c. Plan for the Coming Year**

The perinatal nurse consultant will continue to monitor the status of low birthweight deliveries in Alaska. She will continue to distribute materials and be involved in activities and partnerships that promote improved birth outcomes, generally. This will include completion of the grant process for the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting Program, conducting the needs assessment, and, presumably, beginning of program implementation.

Subsequent to discussions in the past, Providence Family Medicine Clinic and its family medicine residency program has decided to implement the CenteringPregnancy model and the perinatal nurse consultant will support their efforts, as needed. She will continue to support March of Dimes through consultation with their state director and membership on the program services committee, and support other agencies and individuals, as possible.

WCFH will continue to conduct outcome data analyses, including more thoroughly elucidating where very low birthweight babies are born when they aren't born at the tertiary care hospital.

Possible future activities more specific to low birthweight include:

Contact MCH case managers at ANTHC to discuss their policies and will offer educational support to direct-entry.

Meet with managers at Providence Alaska Medical Center to discuss the possibility of establishing a rural-urban nurse exchange program to help build bridges between health care facilities, improve standards of care and birth outcomes, especially for low birthweight and preterm infants.

Look into the possibility of supporting the Perinatal Continuing Education Program in rural areas.

Explore options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education on the issue.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | 85 | 85 | 85 | 85 | 85 |
| Annual Indicator | 80.5 | 81.3 | 80.3 | 79.8 | |
| Numerator | 8213 | 8688 | 8584 | 8716 | |
| Denominator | 10197 | 10687 | 10689 | 10922 | |
| Data Source | | | | Alaska Bureau of Vital Statistics | Alaska Bureau of Vital Statistics |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 85 | 85 | 85 | 85 | 85 |

**Notes - 2009**
Source: AK Bureau of Vital Statistics. CY 2008 is most recent data available.

**Notes - 2008**
Source: AK Bureau of Vital Statistics. CY 2008 is most recent data available.

**Notes - 2007**
Source: AK Bureau of Vital Statistics. CY 2007is most recent data available.

**a. Last Year's Accomplishments**
The perinatal nurse consultant continued to meet with private health care providers and administrators at facilities across Alaska. She visited the bush town of Dillingham and observed the provision of group prenatal care via teleconference. The perinatal advisory committee met twice, one meeting featuring Sharon Rising of CenteringPregnancy, the evidence-based program that emphasizes early prenatal care and support and reduces preterm birth. WCFH convened a preconception committee that met regularly, where she advocated for inclusion of early prenatal care messages.

A number of activities address prenatal care generally. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

The consultant carried on activities that educated health care providers about the importance of early prenatal care. The perinatal list serve, to share information about evidence-based programs and professional education opportunities, and distribution of other printed materials continued. The WCFH Epi Unit continued to conduct outcome data analyses and update MCH publications.

The perinatal nurse consultant continued to support the program efforts of March of Dimes. While their director of program services position remained vacant, the perinatal nurse consultant served as periodic advisor to the state director. The perinatal nurse consultant was the practicum mentor for a public health nurse and supported the development of a perinatal nurse case manager position in Kotzebue. Also, the Section of WCFH participated in the Municipality of Anchorage's Healthy Anchorage Indicator project, focused on MCH.

In February 2009, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) to conduct a conference. Aspects of early prenatal care were addressed in sessions on progesterone for preterm labor, polycystic ovarian syndrome, and herbal therapy for women of reproductive age.

Delay in the processing of Medicaid applications for newly pregnant women, a problem in prior years, no longer continued to be the major cause of delays in initiating prenatal care. This occurred following an effort of the Title V MCH director and Medicaid working together.

The Section of WCFH continued to investigate ways to support high risk mothers in Alaska, since public health nursing home visits are no longer available in the Anchorage area, except to clients eligible for Alaska Native health services. Coming up with an affordable, effective home visiting program continued to be of interest, including integration of tobacco and other substance cessation interventions.

We have not had improvement in over 10 years in the percent of infants born to women beginning prenatal care in the first trimester, and in some areas of the state fewer than 55% of pregnant women begin prenatal care in the first trimester, such as in the Wade Hampton area of Southwest Alaska.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Convene perinatal advisory committee on a regular basis and spotlight key perinatal programs and issues. | | | | X |
| 2. Support March of Dimes, counseling the state director and serving on the program services committee, the Municipality of Anchorage, public health nursing, and others to improve perinatal outcomes. | | | | X |
| 3. Participate in preconception planning efforts, including a component to encourage early prenatal care. | | | X | X |
| 4. Plan and conduct joint MCH conference in 2010, including topics with implications for early prenatal care. | | | | X |
| 5. Conduct MCH outcome data analyses and update MCH publications. | | | | X |
| 6. Continue the perinatal list serve and distribution of printed materials, such as the Healthy Mother, Healthy Baby Diaries and Alaska MCH Data Books. | | | X | X |
| 7. Closely follow national health care reform legislation and respond to requirements for ACA’s home visiting program. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Activities from last year have continued. The perinatal advisory committee met in November 2009. The perinatal nurse consultant continues to support March of Dimes through consultation with their new director of program services and membership on the program services committee, and supports other agencies and individuals, as possible. She continued to play an active role in the preconception committee and advocated for inclusion of early prenatal care messages until the committee was suspended in January 2010.

The MCH Epi Unit continues to conduct outcome data analyses. Their publications, along with previously mentioned materials, are distributed via personal delivery, mail, and electronically.

The Section of WCFH and Alaska Native Tribal Health Consortium have planned a 3-day MCH conference in September 2010 that will include topics relevant to early prenatal care such as prenatal alcohol and tobacco exposure and cessation, domestic violence, maternal depression, and cultural and linguistic competence.

The Section of WCFH has closely followed national health care reform legislation and is working to complete the first Affordable Care Act application to fund prenatal home visitation.

The section supported state legislative efforts, as requested, to increase the eligibility for Alaska's SCHIP for pregnant women. Despite overwhelming popular and legislative support, Alaska's Governor vetoed a bill to increase access to Alaska's SCHIP.

**c. Plan for the Coming Year**

The major focus of the coming year is completion of the grant process for the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting Program, conducting the needs assessment, and, presumably, beginning of program implementation.

General activities to promote early prenatal care will continue. The perinatal nurse consultant expects to conduct an update, revision, printing and distribution of the Healthy Mother, Healthy Baby Diaries. This year will see publication of a new MCH Data Book on FASD.

Subsequent to discussions in the past, Providence Family Medicine Clinic and its family medicine residency program has decided to implement the CenteringPregnancy model and the perinatal nurse consultant will support their efforts, as needed.

As March of Dimes recently finally filled their long-vacant director of program services position, the perinatal nurse consultant hopes to collaborate on projects of mutual interest. The popular Alaska folic acid pamphlet that was originally developed jointly with March of Dimes is due to be revised and reprinted and would be a fitting collaborative project.

We have not had improvement in over 10 years in the percent of infants born to women beginning prenatal care in the first trimester and this issue will continue to be monitored. However, in light of evidence indicating early prenatal care may not influence outcomes as much as once believed and the recent evidence around the life course perspective, WCFH hopes to shift more attention to preconception health in the coming year.

## D. State Performance Measures

**State Performance Measure 1:** *Percentage of mothers of newborns who say their physician or health plan would not start prenatal care as early as they wanted or they could not get an appointment as early as they wanted.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 15 | 15 | 15 | 15 |
| Annual Indicator | 12.5 | 16.5 | 14.8 | 17.1 | |
| Numerator | 1209 | 1716 | 1517 | 1844 | |
| Denominator | 9697 | 10426 | 10275 | 10782 | |
| Data Source | | | | AK PRAMS. | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 15 | 15 | 15 | 13 | |

**Notes - 2009**
Source: AK PRAMS. The latest available data is 2008.

**Notes - 2008**
Source: AK PRAMS. The latest available data is 2008.

**Notes - 2007**
Source: AK PRAMS. The latest available data is 2007.

**a. Last Year's Accomplishments**
The perinatal nurse consultant continued to meet with and private health care providers and administrators at facilities across Alaska. She visited the bush town of Dillingham and observed the provision of group prenatal care via teleconference. The perinatal advisory committee met twice, one meeting featuring Sharon Rising of CenteringPregnancy, the evidence-based program that emphasizes early prenatal care and support and reduces preterm birth. WCFH convened a preconception committee that met regularly, where she advocated for inclusion of early prenatal care messages.

A number of activities address prenatal care generally. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

The consultant carried on activities that educated health care providers about the importance of early prenatal care. The perinatal list serve, to share information about evidence-based programs and professional education opportunities, and distribution of other printed materials continued. The WCFH Epi Section continued to conduct outcome data analyses and update MCH publications.

The perinatal nurse consultant continued to support the program efforts of March of Dimes. While their director of program services position remained vacant, the perinatal nurse consultant served as periodic advisor to the state director. The perinatal nurse consultant was the practicum mentor for a public health nurse and supported the development of a perinatal nurse case manager position in Kotzebue. Also, the Section of WCFH participated in the Municipality of Anchorage's Healthy Anchorage Indicator project, focused on MCH.

In February 2009, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) to conduct a conference. Aspects of early prenatal care were addressed in sessions on progesterone for preterm labor, polycystic ovarian syndrome, and herbal therapy for women of reproductive age.

Delay in the processing of Medicaid applications for newly pregnant women, a problem in prior years, no longer continued to be the major cause of delays in initiating prenatal care. This occurred following an effort of the Title V MCH director and Medicaid working together.

The Section of WCFH continued to investigate ways to support high risk mothers in Alaska, since public health nursing home visits are no longer available in the Anchorage area, except to clients eligible for Alaska Native health services. Coming up with an affordable, effective home visiting program continued to be of interest, including integration of tobacco and other substance cessation interventions.

The percent of pregnant women who say MD or health plan would not start prenatal care when they wanted to start increased from14.8% in 2007 to 17.1% in 2008.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Convene perinatal advisory committee on a regular basis and spotlight key perinatal programs and issues. | | | | X |
| 2. Support March of Dimes, counseling the state director and serving on the program services committee, the Municipality of Anchorage, public health nursing, and others to improve perinatal outcomes. | | | | X |
| 3. Participate in preconception planning efforts including a component to encourage early prenatal care. | | | X | X |
| 4. Plan and conduct joint MCH conference in 2010, including topics with implications for early prenatal care. | | | | X |
| 5. Conduct MCH outcome data analyses and update MCH publications. | | | X | X |
| 6. Continue the perinatal list serve and distribution of printed materials, such as the Healthy Mother, Healthy Baby Diaries and Alaska MCH Data Books. | | | X | X |
| 7. Closely follow national health care reform legislation and respond to requirements for ACA's home visiting program. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Activities from last year have continued. The perinatal advisory committee met in November 2009. The perinatal nurse consultant continues to support March of Dimes through consultation with their new director of program services and membership on the program services committee, and supports other agencies and individuals, as possible. She continued to play an active role in the preconception committee and advocated for inclusion of early prenatal care messages until the committee was suspended in January 2010.

The MCH Epi Unit continues to conduct outcome data analyses. Their publications, along with previously mentioned materials, are distributed via personal delivery, mail, and electronically.

The Section of WCFH and Alaska Native Tribal Health Consortium have planned a 3-day MCH conference in September 2010 that will include topics relevant to early prenatal care such as prenatal alcohol and tobacco exposure and cessation, domestic violence, maternal depression, and cultural and linguistic competence.

The Section of WCFH has closely followed national health care reform legislation and is working to complete the first Affordable Care Act application to fund prenatal home visitation.

The section supported state legislative efforts, as requested, to increase the eligibility for Alaska's SCHIP for pregnant women. Despite overwhelming popular and legislative support, Alaska's Governor vetoed a bill to increase access to Alaska's SCHIP.

**c. Plan for the Coming Year**

The major focus of the coming year is completion of the grant process for the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting Program, conducting the needs assessment, and, presumably, beginning of program implementation.

General activities to promote early prenatal care will continue. The perinatal nurse consultant expects to conduct an update, revision, printing and distribution of the Healthy Mother, Healthy Baby Diaries. This year will see publication of a new MCH Data Book on FASD.

Subsequent to discussions in the past, Providence Family Medicine Clinic and its family medicine residency program has decided to implement the CenteringPregnancy model and the perinatal nurse consultant will support their efforts, as needed.

As March of Dimes recently finally filled their long-vacant director of program services position, the perinatal nurse consultant hopes to collaborate on projects of mutual interest. The popular Alaska folic acid pamphlet that was originally developed jointly with March of Dimes is due to be revised and reprinted and would be a fitting collaborative project.

We have not had improvement in over 10 years in the percent of infants born to women beginning prenatal care in the first trimester and this issue will continue to be monitored. However, in light of evidence indicating early prenatal care may not influence outcomes as much as once believed and the recent evidence around the life course perspective, WCFH hopes to shift more attention to preconception health in the coming year.

**State Performance Measure 2:** *Percent of women who smoked during the last 3 months of pregnancy among women who smoked 3 months prior to pregnancy and were talked to about the effects of smoking by a prenatal health care provider.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 99 | 99 | 60 | 60 |
| Annual Indicator | 53.8 | 51.5 | 60.1 | 54.3 | |
| Numerator | 1283 | 1314 | 1431 | 1425 | |
| Denominator | 2383 | 2550 | 2382 | 2624 | |
| Data Source | | | | AK PRAMS. | AK PRAMS |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 60 | 60 | 60 | 55 | |

**Notes - 2009**
Source: AK PRAMS. The latest available data is 2008.

**Notes - 2008**
Source: AK PRAMS. The latest available data is 2008.

**Notes - 2007**
Source: AK PRAMS. The latest available data is 2007.

**a. Last Year's Accomplishments**
The perinatal nurse consultant continued to meet with private health care providers and administrators at facilities across Alaska. She visited the bush town of Dillingham and observed the provision of group prenatal care via teleconference. The perinatal advisory committee met twice, one meeting featuring a presentation about tobacco cessation efforts in Alaska, including the Alaska Quit Line. WCFH convened a preconception committee that met regularly. Tobacco cessation was a topic of consideration.

The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care (including the effects of tobacco), and tobacco cessation booklets furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

The consultant carried on activities that educated health care providers about the importance of early prenatal care. The perinatal list serve and distribution of printed materials continued, sharing information about evidence-based programs and professional education opportunities, including those related to tobacco. The WCFH Epi Section continued to conduct outcome data analyses and update MCH publications, including data related to tobacco.

The perinatal nurse consultant convened a steering committee, including a Healthy Native Babies consultant, and launched an infant safe sleep initiative. The role of tobacco was to be an important aspect.

The tobacco program hired a cessation grant manager and she and the perinatal nurse consultant started making plans to collaborate on development and distribution of some materials.

Free and Clear, for the third and final year of their contract, provided Alaska Quit Line services. In addition to a more intensive follow-up for pregnant smokers, they began developing protocols specific for pregnant callers. Additional training in quit coach college was provided to enhance counseling pregnant women. The perinatal nurse consultant will continue to support the Quit Line through education and referral efforts.

The tobacco program continued to participate on the Medicaid workgroup of the Alaska Tobacco Control Alliance to support the provision of cessation services. They worked to implement greater availability of treatment strategies, including reimbursement for pharmacists.

The Section of WCFH continued to investigate ways to support high risk mothers in Alaska, since public health nursing home visits are no long available in the Anchorage area, except to clients eligible for Alaska Native health services. Coming up with an affordable, effective home visiting program continued to be of interest, including integration of tobacco and other substance cessation interventions.

In 2008, 54.3% of women who smoked 3 months prior to pregnancy and were talked to about tobacco effects by a prenatal provider continued to smoke during pregnancy. This is an improvement from 60.1% in 2007.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. WCFH and state tobacco program collaborate on projects related to tobacco cessation education for pregnant women and their health care providers. | | | | X |

| | | | | |
|---|---|---|---|---|
| 2. Address the role of tobacco in infant sleep-related deaths via the infant safe sleep project. | | | | X |
| 3. Provide expanded and specialized Alaska Quit Line services for pregnant women, by adding Alaska-specific training. | | | | X |
| 4. Participate in the Alaska Tobacco Control Alliance Medicaid workgroup to advocate for improved coverage for tobacco cessation services. | | | | X |
| 5. Conduct MCH conference to include role of tobacco on the health of MCH populations. | | | | |
| 6. Collaborate with Tobacco Program on an analysis of PRAMS data. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

General activities from last year have continued. The perinatal advisory committee met in November 2009. The perinatal nurse consultant distributes tobacco cessation booklets to providers of health care. The consultant supports March of Dimes through membership on the program services committee, and supports other agencies and individuals, as possible. She played an active role in the preconception committee, in which tobacco was an important topic, until the committee was suspended in January 2010.

The Tobacco Program and MCH Epi Unit are collaborating on an analysis of PRAMS tobacco data. Their publications, along with previously mentioned materials, are distributed via personal delivery, mail, and electronically.

The infant safe sleep initiative and role of tobacco is a major focus. WCFH and Alaska Native Tribal Health Consortium have planned a 3-day MCH conference in September 2010 that will address tobacco, among other topics.

The tobacco program and WCFH are collaborating on distributing materials. The Free and Clear contract to provide Alaska Quit Line services was renewed and has added Alaska-specific training related to chew tobacco, including iqmik. The consultant supports the Quit Line through education and referral efforts.

The tobacco program works through ATCA to advocate for increased Medicaid reimbursement for provision of tobacco cessation services, recently gaining reimbursement for pharmacists to conduct brief tobacco cessation interventions.

**c. Plan for the Coming Year**

The perinatal nurse consultant will continue activities from the prior year. She will continue to work with the tobacco control program on material development and distribution. Also, the consultant will explore the idea of working with the tobacco program to develop a rack card to promote the Alaska Quit Line's pregnant caller services.

A major focus of the coming year is completion of the grant process for the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting Program, conducting the needs assessment, and, presumably, beginning of program implementation. Tobacco cessation services will be included.

Other possibilities include: renewing efforts to reprint the popular Alaska Native tobacco cessation

booklet (copyright concerns have delayed that work); exploring the American Academy of Family Physicians' resources for tobacco cessation materials for health care providers and options for partnering with other health care provider groups, e.g. family medicine physicians and public health nurses to provide cessation education; and, working with ATCA on a PSA addressing pregnant women and tobacco.

Funds that were to go to a mini-grant program instead will be used for the Alaska Infant Safe Sleep Initiative, part of which will address the role of tobacco in infant death.

**State Performance Measure 3:** *Percentage of children ages 10-11 who are at-risk for being overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 0 | 0 | 35 | 35 |
| Annual Indicator | 40.1 | 40.1 | 40.1 | 39.7 | 39.7 |
| Numerator | 6783 | 6783 | 6783 | | |
| Denominator | 16901 | 16901 | 16901 | | |
| Data Source | | | | National Survey of Children's Health, 2007 | National Survey of Children's Health, 2007 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 35 | 35 | 35 | 35 | |

**Notes - 2009**
Source: National Survey of Children's Health, 2007. Starting with the survey year 2007, this indicator is reported for 10 - 13 year olds and represents overweight and obese, 85th percentile and above.

**Notes - 2008**
Source: National Survey of Children's Health, 2007. Starting with the survey year 2007, this indicator is reported for 10 - 13 year olds and represents overweight and obese, 85th percentile and above.

**Notes - 2007**
Source: National Survey of Children's Health, Alaska, 2003, Physical and Dental Health. No new information since 2003.

**a. Last Year's Accomplishments**
The Obesity Prevention and Control Program (OPCP) staff presented evidence-based obesity prevention strategies to a variety of professional audiences. It coordinated with partners to host the 2009 School Health & Wellness Institute. OPCP trained over 162 child care providers on physical activity and nutrition through 14 trainings held in 9 Alaskan communities: Anchorage (3), Juneau (2), Fairbanks (2), Nome (2), Mat-Su, Homer, Ketchikan, Sitka, and Bethel. The program financially supported professional education opportunities at the HRSA Business Case for Breastfeeding in the Workplace. It provided a poster presentation at the Weight of the Nation conference regarding our findings: Prevalence of Overweight and Obesity among Anchorage School District Students, 1998-2008.

OPCP promoted 2009 Bike to Work and School Day. 191 Worksite Bike to Work Teams (about 2,400 riders) signed up to participate. 1,787 riders were observed at 12 stations around Anchorage; a 26% increase over the 2007 observed rider baseline.

OPCP supported the Get Outdoors! Alaska coalition in the development of an implementation plan to increase the amount of time children, youth and families spend outdoors.

The OPCP was appropriated funding from the legislature to fund a long term, comprehensive child obesity prevention initiative.

OPCP collected additional surveillance questions for both the 2009 YRBS (sugar sweetened beverage consumption) and the 2009 BRFSS (computer viewing; barriers to fruit and vegetable consumption, how much responsibility does individual, government, schools have in addressing the obesity epidemic).

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The Alaska OPCP provides credible information about evidence-based obesity prevention strategies, programs, and opportunities for health professionals, partner agencies, individuals and the media. | | | | X |
| 2. Support Alaska OPCP surveillance data collection that evaluates AK behaviors & risk factors; recommend effective solutions for building community coalitions and partnerships to track health outcomes; evaluate overall effectiveness. | | | | X |
| 3. The program facilitates professional development for school and health professionals. | | | | X |
| 4. The Alaska OPCP builds the capacity of a variety of coalitions to strengthen statewide obesity prevention efforts. Clearly the people at the local level are the ones that can make change happen in the communities in which they live, work, and play. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

OPCP provides evidence-based information on obesity prevention strategies, programs, and opportunities for health professionals, partner agencies, individuals and the media. Publications include: Obesity Facts: Sugar-Sweetened Beverages in Alaska (2010) , The Burden of Overweight and Obesity in Alaska (2010) , 2009 Status Report: Obesity Prevention and Control Program (2010). In coordination with the CDC, OPCP provides surveillance data and publishes reports on the behaviors and risk factors that contribute to obesity. The program facilitates professional development for school and health professionals.

OPCP works with a variety of coalitions to strengthen statewide obesity prevention efforts. The program helps the Alaska Dental Access Coalition develop strategies to decrease sugar-sweetened beverage consumption and dental caries. It provides nutrition related evidence-based research and consultation to the Coordinated School Health (CSH) Partnership. It is developing,

in partnership with various stakeholders, the State of Alaska Physical Education Standards for adoption by the State Board of Education. OPCP is participating in the development of the Alaska Education Plan, the state's first blueprint for public education. It provides technical expertise around nutrition and physical activity to the Intradepartmental Early Childhood Coordinating Council. It incorporates the national recommendations for physical activity in the Get Outdoors Alaska! messages for children

**c. Plan for the Coming Year**
OPCP plans to facilitate meetings of the Food Policy Council for shared planning, implementation, and sustainability of program efforts.

OPCP staff will provide presentations at a minimum of 6 conferences or meetings and will provide professional education opportunities with national speakers for partners at statewide conferences or meetings to increase knowledge about obesity issues.

OPCP will assist in planning and coordinating the annual School Health and Wellness Institute that supports the implementation of wellness policies based on evidence-based programs and practices.

School districts will receive technical assistance from OPCP on the implementation of wellness policies based on evidence-based programs and practices.

OPCP will partner with Bicycle Commuters of Anchorage, Get Outdoors, and others to promote Bike to Work Day and increased outdoor physical activity and play.

Plans to continue developing a comprehensive child obesity initiative and secure more state funding are ongoing.

OPCP intends to identify new surveillance sources or opportunities to add nutrition-, physical activity- and obesity-related questions. Proposed opportunities include expansion of the school BMI data collection and analysis project to the Mat-Su Borough School District and analysis and report of WIC recipients prevalence of obesity and associated nutrition behaviors. OPCP will expand the surveillance plan to address current surveillance needs in relationship to the evaluation measures of the state plan and implementation plan.

Notes: Source: National Survey of Children's Health, 2007. Starting with the survey year 2007, this indicator is reported for 10 - 13 year olds and represents overweight and obese, 85th percentile and above.

Numerator: Number of children who are at-risk for being overweight as defined by NCHS BMI classification.
Denominator: Total number of children ages 10-11 years in Alaska.

**State Performance Measure 4:** *Rate (per 1,000) of substantiated reports of harm children ages 0 through 18.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 17 | 17 | 17 | 12 | 12 |
| Annual Indicator | | 15.2 | 14.8 | 19.0 | 18.1 |
| Numerator | | 3113 | 3209 | 3757 | 3612 |
| Denominator | | 205460 | 217105 | 197471 | 199773 |
| Data Source | | | | AK Office of Children's Services | AK Office of Children's Services |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 12 | 12 | 12 | 12 | |

**Notes - 2009**
Substantiated Victims is the unique count of substantiated victims in NCANDS. Population is the count of Alaskans age 0 to 17, Dept. of Labor estimates. Date of data extraction: March 10th, 2010

**Notes - 2007**
Data source: AK Office of Children's Services

The numerator for 2006 is changed from 4543 to 3113. This corrects an error last year in the interpretation of the definition of the numerator. To reconfirm, the numerator is the 'count of children with at least one allegation substantiated'.

**a. Last Year's Accomplishments**
The State Strengthening Families Leadership Team partnered with the United Way of Anchorage, the Alaska Children's Trust and the Alaska Child Care Resource and Referral Network to expand the number of SF programs in the Anchorage area. 10 new early care and learning programs were recruited, staff were trained and supported with technical assistance. An evaluation process was developed and initiated to assess program staff and family outcomes. Additionally, conversations with family support agencies began about how SF tools and information might be adapted to their work.

OCS funding was utilized to print a curriculum for a course on "Engaging Families". This curriculum was distributed to the Child Care Resource and Referral Agencies in Juneau and Fairbanks to expand training to early care and learning programs in the state.

OCS continued to focus on embedding the Strengthening Families protective factors framework in state policies and systems, including in training for all new social workers and embedding protective factors language in grant requirements.

OCS collaborated with the Alaska Children's Trust on the development of a statewide child abuse and neglect prevention plan and the PREVENT Maltreatment Project. Both projects incorporated the protective factors and the use of community cafés to engage parents and community members in discussions. In addition, The Strengthening Families Leadership Team developed a strategic plan to set direction for the next three years.

Statewide monthly "Strengthening Families Learning Network" conference calls have continued. Each month a speaker is invited to share information about a family support related topic.

Alaska SCAN supported by Title V funds and located in the Title V MCH agency, continues to gather data on child maltreatment from a variety of sources to help tract and intervene related to

child maltreatment.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Work toward statewide expansion of SF model through Anchorage UW partnership, curriculum materials for Juneau and Fairbanks, and conference presentations. | | | | X |
| 2. Engage family support agencies in conversations about SF tools and framework. | | | | X |
| 3. Offer training through conferences and special events. | | | | X |
| 4. Work to embed this framework in state policies and systems through Family & Youth Training Academy and grant language. | | | | X |
| 5. Continue to support SF programs through the Learning Network. | | | | X |
| 6. Partner with Alaska Children's Trust on community café projects. | | | X | |
| 7. Develop new SF materials for distribution. | | | X | |
| 8. Implement strategic plan. | | | | X |
| 9. Continue to gather data on child maltreatment from a variety of sources through Alaska SCAN to help tract and intervene related to child maltreatment. | | | | X |
| 10. | | | | |

**b. Current Activities**

OCS is partnering with United Way, Alaska Children's Trust, Alaska Parent Resource Center, Department of Education and Early Development, and Child Care Resource and Referral Network to support expansion of the Strengthening Families model in the Anchorage area. Two new parents have been recruited and oriented for the Leadership Team which is attending and presenting at the National Strengthening Families Leadership Institute. Judy Langford, founder of Strengthening Families is planned to speak to 170 early childhood professionals this year.

Ten early care and learning programs are receiving support and technical assistance; evaluation data is being collected and analyzed.

"Learning Network" conference calls are continuing as is a training at Anchorage School District for staff, and family support agencies in the "Stronger Together" curriculum. Presentations are being offered at major early childhood conferences.

OCS is continuing to partner with the Alaska Children's Trust (ACT) in the expansion of "Community Cafes" to encourage dialogue about strengthening families programs; OCS and ACT is co-facilitating quarterly "Community Café Cluster Group" meetings for the National Alliance of Children's Trusts.

Alaska SCAN is continuing to provide the necessary information to guide and support the efforts of all the different agencies in Alaska concerned with reducing child maltreatment. Alaska SCAN is supported by Title V funds and located in the Title V MCH agency.

**c. Plan for the Coming Year**

Next year the Strengthening Families Leadership Team will update the strategic plan.
We will be expanding our outreach to early care and learning programs across the state. Training

will be offered at conferences, university classes and programs as requested. We will continue to expand our partnerships and continue to search for additional funding. The Strengthening Families website will be improved and a Strengthening Families electronic newsletter will be developed. A "core knowledge" resource will be developed and embedded in the Early Childhood Professional Development Plan.

The Strengthening Families Leadership Team will continue to support the Child Care Resource and Referral Network (CCRRN) in their work with early care and learning programs. With new funding from United Way, the CCRRN will continue to support the existing Strengthening Families programs in and Anchorage and begin to embed Strengthening Families concepts into their existing training and professional development efforts.

OCS will continue to partner with the Alaska Children's Trust in expanding the use of Community Cafes.

**State Performance Measure 5:** *Percentage of women who recently had a live-born infant who reported their prenatal health care provider advised them not to drink alcohol during their pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 99 | 99 | 99 | 99 |
| Annual Indicator | 79.5 | 82.6 | 80.0 | 82.6 | |
| Numerator | 7629 | 8481 | 8326 | 8847 | |
| Denominator | 9598 | 10268 | 10402 | 10714 | |
| Data Source | | | | AK PRAMS | AK PRAMS |
| Is the Data Provisional or Final? | | | | Provisional | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 99 | 99 | 99 | 99 | |

**Notes - 2009**
Source: AK PRAMS. The latest available data is 2008.

**Notes - 2008**
Source: AK PRAMS. The latest available data is 2008.

**Notes - 2007**
Source: AK PRAMS. The latest available data is for 2007.

**a. Last Year's Accomplishments**
The Epidemiology Unit of WCFH began work on a special edition of the MCH Data Book that will feature the first comprehensive data published on FASD since the inception of the FAS surveillance program. The data featured in this edition will represent data collected between 1996 and 2002. Staff worked on completing abstractions and re-abstractions on records of all children reported to the Alaska Birth Defects Registry (ABDR) as having been affected by maternal alcohol exposure during birth years 1996-2002. The senior MCH epidemiologist authored and published an Epi Bulletin with birth defects prevalence data, including FASD, for birth years 1996-2002. ABDR staff met with the director and staff of the new Arctic FASD Regional Training Center to discuss potential for collaboration and provider education. The ABDR Coordinator participated in the preconception and perinatal advisory committees to support birth defects/FASD prevention. We published and distributed the Alaska Birth Defects Monitor, a newsletter about birth defects in Alaska, including FASD.

The perinatal nurse continued to meet with public and private health care providers and administrators at facilities across Alaska to assess perinatal health needs, collaborate on program development, and evaluate efforts. She visited the bush town of Dillingham. She held two perinatal advisory committee meetings. Alcohol use during pregnancy, among other topics, was discussed.

A number of her activities addressed prenatal care generally. In addition to providing continuing education opportunities for health care providers, the perinatal list serve continued to be used to share information about evidence-based programs and professional education opportunities, including those related to FASD prevention.

The Healthy Mother, Healthy Baby Diary, that includes FASD among other health education topics on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

In 2008 82.6% of women who recently delivered a baby reported having been advised to avoid alcohol by their health care provider. This edged up from 80.0% in 2007, but generally remains steady since 2004.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue funding the ABDR/FAS data surveillance program with the MCH Block Grant. | | | | X |
| 2. Conduct FASD data cleaning and analysis in preparation for MCH Data Book publication on FASD. | | | | X |
| 3. Develop and distribute interim publications based on FASD data analysis. | | | | |
| 4. Continue health care provider education regarding alcohol abstinence during pregnancy, including the sharing of prevalence rates of FAS. | | | | X |
| 5. Update and continue distribution across Alaska of WCFH and other materials. | | | | X |
| 6. Continue regular distribution of Alaska Birth Defects Monitor, a newsletter that includes FASD. | | | | X |
| 7. Address FASD prevention in preconception committee efforts. | | | | X |
| 8. Include sessions on prenatal alcohol in 3-day MCH conference in September 2010. | | | | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Under the ABDR, FAS surveillance activities continue using the CDC FASSNet model. Work continues on the special FASD edition of the MCH Data Book and interim publications. MCH Epi staff presented FAS prevalence data to health care providers, the Arctic FASD Regional Training center staff, and individuals who work with families and children affected by FASD. The ABDR coordinator participated in the preconception and perinatal health committees to support birth defects/FASD prevention.

The perinatal nurse consultant's activities from the past year continue. The perinatal advisory committee met twice. The Section of WCFH and Alaska Native Tribal Health Consortium have planned a 3-day MCH conference in September 2010 that will include topics relevant to prenatal

alcohol use with sessions entitled, "She Drank Before She Knew" and "Using Data to Tell Stories." WCFH convened a preconception committee which was to have addressed FASD, among other topics, but was temporarily suspended.

The Section of WCFH has closely followed national health care reform legislation and is working to complete the first Affordable Care Act application to fund prenatal home visitation.

**c. Plan for the Coming Year**

MCH Epi staff will continue to work on a special edition of the MCH Data Book focusing on FASD. The data book will be published via the web and hard copy and distributed to as many providers of obstetrical and newborn care as possible. Medical records abstractions for children reported to the ABDR as having been affected by maternal alcohol exposure will continue.

WCFH will continue to work collaboratively with the newly established Arctic FASD Regional Training Center in Anchorage to reach health care providers statewide with information about FASD prevalence and high risk populations so that they may better target prevention efforts and be informed about trends over time. The ABDR coordinator will participate in the preconception and perinatal health committees to support birth defects/FASD prevention. MCH Epi will also continue to publish the Alaska Birth Defects Monitor newsletter.

The perinatal nurse consultant will continue to distribute WCFH-published data and other selected materials, including those on FASD prevention. A revision of the Healthy Mother, Healthy Baby Diary, that includes FASD prevention information, will get into full swing in the coming year, in anticipation of a reprinting.

The perinatal advisory committee will meet later in the year. Tentatively, FASD will be the focus of the spring 2011 meeting. The consultant will continue to pursue options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education on FASD.

As March of Dimes recently finally filled their long-vacant director of program services position, the perinatal nurse consultant hopes to collaborate on projects of mutual interest. The popular Alaska folic acid pamphlet that was originally developed jointly with March of Dimes is due to be revised and reprinted and would be a fitting collaborative project related to the prevention of birth defects.

A major focus of the coming year is completion of the grant process for the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting Program, conducting the needs assessment, and, presumably, beginning of program implementation. It is hoped Alaska can incorporate a strong component related to alcohol prevention, referral, and treatment.

Other possibilities include: partnering with Alaska Division of Behavioral Health to distribute FASD materials and recognize Birth Defects Prevention Month in January; working with the Anchorage FASD coalition to promote and recognize FAS Awareness Day in September; and exploring options to support expanding early prenatal care referral at facilities that provide pregnancy testing and at pregnancy test point of purchase, including advice to avoid alcohol, tobacco and other substances.

**State Performance Measure 6:** *Prevalence (per 100) of unintended pregnancies that resulted in a live birth among women who reported having a controlling partner during the 12 months prior to getting pregnant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 35 | 35 | 35 | 35 |
| Annual Indicator | 51.1 | 69.4 | 50.7 | 57.2 | |
| Numerator | 191 | 245 | 219 | 289 | |
| Denominator | 374 | 353 | 432 | 505 | |
| Data Source | | | | AK PRAMS | AK PRAMS |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 35 | 35 | 35 | 35 | |

**Notes - 2009**
Source: AK PRAMS. The latest available data is for 2008.

**Notes - 2008**
Source: AK PRAMS. The latest available data is for 2008.

**Notes - 2007**
Source: AK PRAMS. The latest available data is for 2007.

The data for this reporting year marked decreased from the year prior and is closer to the rates reported in 2004 and 2005. Staff will monitor future data to ascertain if this is an ongoing trend or not.

**a. Last Year's Accomplishments**
The prevalence of unintended pregnancies that resulted in a live birth among women who reported having a controlling partner during the 12 months prior to getting pregnant increased to 57.3 in 2008 from 50.7 in 2007.

The Alaska Family Violence Prevention Project (AFVPP) and the State Adolescent Health Program (AHP) served on the steering committees for The Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Program and Rape Prevention Education (RPE), primary prevention initiatives for intimate partner violence and sexual assault.

The AFVPP and the AHP assisted with pilot testing and adapting the Fourth R prevention curriculum for Alaskan high school students. They collaborated on a grant proposal to fund evaluation of the Fourth R prevention curriculum in several high schools.

The AFVPP developed a curriculum for service providers on adolescent brain development, dating violence, and sexual risk behaviors including birth control sabotage and unintended pregnancies.

The AFVPP conducted training on intimate partner violence in Anchorage, Sitka, Juneau, Kenai, Homer, and web-based training for public health nurses. They also provided technical assistance on screening for health care providers. AFVPP provided education on the adolescent brain development, dating violence and risk behaviors in Anchorage, Sitka, Homer, Girdwood, and Dillingham.

Other accomplishments included publishing an article on adolescent brain development and risk behaviors. The AFVPP Clearinghouse continued to develop and distribute tools and resources.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue to operate the clearinghouse to disseminate resources on intimate partner violence and reproductive coercion throughout Alaska. | | | | X |
| 2. Develop a curriculum for service providers on reproductive health and violence and pilot the curriculum in Anchorage, Homer, Fairbanks, and Dillingham. | | | X | X |
| 3. Participate in national and Alaska-based initiatives and data collection on reproductive health. | | | X | X |
| 4. Write and submit a chapter on primary prevention for publication in a medical textbook. | | | | X |
| 5. Establish a reproductive health and violence teleconference network and list-serve with periodic updates of what is happening in the field. | | | | X |
| 6. Work on a Research Grants for Preventing Violence and Violence –Related Injury (R01) proposal to evaluate a prevention curriculum on healthy relationships, sexuality, and substance abuse in schools. | | | | X |
| 7. Conduct a statewide, on-line survey on reproductive coercion and dating violence with public health nurses. | | | | X |
| 8. Participate on the steering committee for national conference and present at pre-conferences and a national round table on violence and reproductive health. | | | | X |
| 9. Co-create, implement, monitor and evaluate a statewide dating violence prevention and youth leadership campaign entitled “Stand Up Speak Up “ | | | | X |
| 10. | | | | |

**b. Current Activities**

The AFVPP is submitting a chapter on the primary prevention of intimate partner violence for a medical textbook. It also is doing a television interview and working on the Alaska League of Women Voters position paper on violence against women.

The AFVPP is presenting at pre-conferences on reproductive health and violence at the National Conference on Domestic Violence and Health Care and a national round-table on reproductive coercion. It is doing keynote presentations with content on healthy relationships for two regional Girl Scout events. It is also initiating statewide teleconferences on reproductive health and violence and creating a list serve to disseminate research and resources. The AFVPP Clearinghouse is disseminating a DVD and posters on reproductive health and violence.

The AFVPP is participating in an initiative to increase access to reproductive health care in southwestern Alaska and assisting in the design and implementation of a reproductive health survey. It also is conducting a statewide, on-line survey on reproductive coercion and dating violence with public health nurses. The AFVPP is developing a curriculum for health care providers on reproductive coercion and piloting this curriculum at hospitals and clinics in Alaska.

The AHP collaborated with non-profit and State agencies to launch the "Stand Up, Speak Up" campaign aimed at reducing unhealthy relationships in teens and increasing youth leadership throughout the state.

**c. Plan for the Coming Year**
The AFVPP will develop and implement a statewide, web-based training on reproductive health and violence/coercion including a three-part train-the-trainer (TTT) component for public health nurses, reproductive health providers, and domestic violence advocates. It will develop and distribute a PowerPoint presentation which includes talking points for speakers and a bibliography on the impact of violence on reproductive health. The AFVPP will provide ongoing support and technical assistance to TTT participants.

The Project will compile information on best practices for assessing for reproductive coercion that will be distributed to reproductive health care providers and work with providers to adapt these questions to be culturally appropriate and responsive to emerging issues such as the prevalence of digital abuse within the context of dating violence that relates to pregnancy pressure, unwanted sex, and other forms of reproductive coercion. It will provide a minimum of three, on-site training on reproductive health and violence/coercion at reproductive health facilities (Planned Parenthood, family planning clinics, Crisis Pregnancy Centers) in different regions of Alaska.

The AFVPP will expand its curriculum on adolescent brain development, dating violence, and risk behaviors to address digital abuse within the content of dating violence relative to pressuring sexual activity, pregnancy coercion, sexting, and unhealthy relationships. The Project will present this expanded curriculum that includes digital abuse at a statewide conference for educators and on-site for school faculties in at least two different regions of the state.

The AFVPP will develop a partnership with behavioral health agencies to provide training on intimate partner violence and reproductive coercion that is designed to reach teens and women with behavioral health problems such as substance abuse and who are therefore at high risk for unintended pregnancies and other forms of reproductive coercion. The curriculum will address the interface between lifetime exposure to violence, intimate partner violence, mental health problems, substance abuse, and risk behaviors related to reproductive health. A PowerPoint presentation with speaker notes will be provided to regional behavioral health agencies, and support and technical assistance will be provided to develop regional trainers. The AFVPP will provide two regional trainings for behavioral health providers.

The AFVPP Clearinghouse will develop and print safety cards on reproductive health and violence/coercion that will be disseminated statewide. They will also disseminate posters and practice guidelines on reproductive health and violence that includes specific content on unintended pregnancies, birth control sabotage, and pregnancy coercion.

**State Performance Measure 7:** *Percentage of women who recently had a live-born infant who reported that they always or often felt down, depressed, or hopeless since their new baby was born.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 1.5 | 9 | 8 | 8 |
| Annual Indicator | 9.3 | 8.5 | 8.3 | 8.0 | |
| Numerator | 914 | 888 | 873 | 876 | |
| Denominator | 9807 | 10485 | 10553 | 10944 | |
| Data Source | | | | AK PRAMS | AK PRAMS |
| Is the Data Provisional or Final? | | | | Final | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 8 | 8 | 8 | 8 | |

**Notes - 2009**

Source: AK PRAMS. The latest available data is for 2008.

**Notes - 2008**
Source: AK PRAMS. The latest available data is for 2008.

**Notes - 2007**
Source: AK PRAMS. The latest available data is for 2007.

**a. Last Year's Accomplishments**
The perinatal mood disorder navigator completed a three-year initiative by The Children's Miracle Network at Providence Alaska Medical Center to investigate and develop resources for families affected by perinatal mood disorders. She provided direct service to families at The Children's Hospital at Providence, both in The Maternity Center and in the Neonatal Intensive Care Unit; offered professional development opportunities and education for providers and their support staffs; and offered a free weekly support group for women suffering from postpartum mood disorders; and served as a community resource for providers and families needing additional support services. The perinatal mood disorder navigator designed and implemented a universal screening protocol for The Maternity Center and Providence. As of September 2009, every woman admitted to The Maternity Center was screened for perinatal anxiety and depression and referred for appropriate follow-up care.

The percentage of women who recently had a live-born infant who reported that they always or often felt down, depressed, or hopeless since the new baby was born decreased from the 10.8 in 2004 to 8.0 in 2009. (PRAMS)

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Conduct professional development opportunities for health care providers who work with young families. | | | | X |
| 2. Conduct assessment, counseling, and referral services to pregnant and postpartum women, both inpatient and outpatient. | X | X | | |
| 3. Conduct a weekly postpartum support group. | | X | | |
| 4. Establish universal screening program at The Providence Maternity Center. | | | X | X |
| 5. Serve as community resource on perinatal mood disorders. | | X | | X |
| 6. Distribute educational materials to health care providers. | | | | X |
| 7. Communicate about collaboration possibilities. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The long-term future of the perinatal mood disorder program had been in question because of lack of funding. However, The Children's Hospital at Providence was able to develop and fund a permanent position for a family counselor to fill a gap in community outpatient services. The full-time family counselor replaces the part-time perinatal mood disorder navigator and continues to: provide professional development opportunities to providers who work with young families, provides direct counseling services, and serves as a community resource for those requesting information and referrals for care of emotional and mental health issues during the perinatal period. A free weekly support group and yoga group is facilitated by this counselor, and on-line and print resources are available for distribution.

The perinatal nurse consultant continues to distribute perinatal depression materials. She also stays in contact with Providence family counselor regarding possible collaboration opportunities.

**c. Plan for the Coming Year**
The perinatal mood disorder program will continue to develop outpatient counseling services, offer a free weekly support group, and facilitate universal screening at The Children's Hospital at Providence. It will also continue to offer professional development opportunities and resources for providers interested in instituting screening in their offices and referring patients for follow-up care.

The WCFH perinatal nurse consultant will continue to support services for perinatal mood disorders by facilitating professional continuing education opportunities, and distributing materials. Title V will provide funds for reproduction of educational packets as possible.

## State Performance Measure 8: *Prevalence at birth (per 1,000) of Fetal Alcohol Spectrum Disorders (FASD).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 5 | 1 | 18 | 18 |
| Annual Indicator | 1.4 | 19.3 | 19.1 | 16.9 | 13.7 |
| Numerator | 41 | 576 | 569 | 505 | 413 |
| Denominator | 29852 | 29852 | 29868 | 29930 | 30037 |
| Data Source | | | | AK Birth Defects Registry | AK Birth Defects Registry |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 17 | 17 | 17 | 17 | |

**Notes - 2009**
FY2011 Data Source: ABVS for the number of live births.

This is for reporting year 2010. Data on the number of children born with Fetal Alcohol Spectrum Disorders (FASD) are based on reports of ICD-9 code 760.71 to the Alaska Birth Defects Registry. Data is presented as 3-year averages - for example, data presented for reporting year 2009 is for children born in 2000-2002. Since more children wil be diagnosed as they get older, the prevalence for any specific cohort will change year to year. For the reporting year 2010, the prevalence of FASD for children born 2001-2003 is 13.8 (n=413, d=30,037), as of May 2010. The average age of diagnosis for FAS is 5-6 years. Due to the small number of annual events that occur in Alaska, rates are presented for three-year birth cohorts.

**Notes - 2008**
Numerator: Number of reported cases of Fetal Alcohol Spectrum Disorders (FASD) during a consecutive three-year time period.

Denominator: Total number of Alaska-resident live births during a consecutive three-year time period.

Data on the number of children born with Fetal Alcohol Spectrum Disorders (FASD) are based on reports of ICD-9 code 760.71 to the Alaska Birth Defects Registry. Data is presented as 3-year averages - for example, data presented for reporting year 2008 is for children born in 1999-2001.

Since more children wil be diagnosed as they get older, the prevalence for any specific cohort will change year to year. For the reporting year 2009, the prevalence of FASD for children born 2000-2002 is 16.9 (n=505, d=29,930), as of April 2009. The average age of diagnosis for FAS is 5-6 years. Due to the small number of annual events that occur in Alaska, rates are presented for three-year birth cohorts.

**Notes - 2007**
Data Source: Alaska Bureau of Vital Statistics for the number of live births.

Data on the number of children born with Fetal Alcohol Spectrum Disorders (FASD) are based on reports of ICD-9 code 760.71 to the Alaska Birth Defects Registry.

For each reporting year, prevalence is calculated for several birth cohorts, but only one cohort is shown in the table. For example, data presented for reporting year 2007 is for children born 1998- 2000, as of May 2008.

Since more children will be diagnosed as they get older, the prevalence for any specific cohort will change year to year.

For the reporting year 2008, the prevalence of FASD for children born 1999 - 2001 is 15.4 (n=462, d=29948), as of May 2008.

The average age of diagnosis for FAS is age 5-6 years. Due to the small number of annual events that occur in Alaska, rates are presented for three-year birth cohorts.

**a. Last Year's Accomplishments**
Under the ABDR, FASD surveillance activities continued using the CDC FASSNet model. ABDR staff completed all medical records abstractions for the 1996-2002 birth cohort and continued data cleaning in preparation for the MCH Data Book that will feature 1996-2002 FASD data, the first comprehensive data published since the inception of the surveillance program. Computer programming staff fully integrated the FASSLink and ABDR databases so that children are linked by a common identifier.

The ABDR coordinator presented preliminary FASD data at statewide meetings. A funding request for state general funds to support ABDR-FAS Surveillance activities was submitted as well as an application to CDC for FAS Surveillance. Some state general funds were awarded beginning in State FY 2010, but not federal CDC funding. ABDR staff met with staff of the new Arctic FASD Regional Training Center to discuss potential for collaboration. MCH Epi published the Alaska Birth Defects Monitor, a newsletter about birth defects in Alaska, including FASD.

The perinatal nurse continued to meet with public and private health care providers and administrators at facilities across Alaska to assess perinatal health needs, collaborate on program development, and evaluate efforts. She visited the bush town of Dillingham. She held two perinatal advisory committee meetings. Alcohol use during pregnancy, among other topics, was discussed.

A number of her activities addressed prenatal care generally. In addition to providing continuing education opportunities for health care providers, the perinatal list serve continued to be used to share information about evidence-based programs and professional education opportunities, including those related to FASD prevention.

The Healthy Mother, Healthy Baby Diary, that includes FASD among other health education topics on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue funding the ABDR/FAS data surveillance program with the MCH Block Grant. | | | | X |
| 2. FASD data cleaning and analysis in preparation for MCH Data Book publication on FASD. | | | | X |
| 3. Develop and distribute interim publications based on FASD data analysis. | | | | X |
| 4. Continue health care provider education regarding alcohol abstinence during pregnancy, including the sharing of prevalence rates of FAS. | | | | X |
| 5. Update and continue distribution across Alaska of WCFH and other materials. | | | | X |
| 6. Continue regular distribution of Alaska Birth Defects Monitor, a newsletter that includes FASD. | | | | X |
| 7. Address FASD prevention in preconception committee efforts. | | | | X |
| 8. Include sessions on prenatal alcohol in 3-day MCH conference in September 2010. | | | | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

FAS surveillance activities continue using the CDC FASSNet model. Data analysis began in preparation for the MCH Data Book that will feature 1996-2002 FASD data. During 1996-2002, Alaska experienced a 32% decrease in FAS birth prevalence from 19.9 to 13.5 per 10,000 live births. Decline in the overall FAS prevalence was limited entirely to Alaska Native children who experienced a 49% decline from 63.1 to 32.4 per 10,000 live births. MCH Epi staff presented FAS prevalence data to health professionals and individuals who work with families and children affected by FASD. MCH Epi staff fulfilled data requests on FASD prevalence. The ABDR coordinator participated in the preconception and perinatal health committees to support birth defects/FASD prevention. MCH Epi published the Alaska Birth Defects Monitor, a newsletter about birth defects in Alaska, including FASD.

The perinatal nurse consultant's activities from the past year continue. The perinatal advisory committee met twice. The Section of WCFH and Alaska Native Tribal Health Consortium have planned a 3-day MCH conference in September 2010 that will include topics relevant to prenatal alcohol use with sessions entitled. WCFH convened a preconception committee which was to have addressed FASD, among other topics, but was temporarily suspended.

The Section of WCFH has closely followed national health care reform legislation and is working to complete the first Affordable Care Act application to fund prenatal home visitation.

**c. Plan for the Coming Year**

Work will continue on the special FASD edition of the MCH Data Book and interim publications. We will post publications on the web and distribute them to as many providers of obstetrical and

newborn care as possible, as well as other relevant health care providers and service organizations. Findings will be presented to major health care providers and educators with the hope that improvements in referral rates for at-risk populations will occur. Data may be helpful in determining the distribution of services offered to children with a diagnosis of FASD and assist in assessing where the gaps in services exist. We will continue abstracting medical records for children born in 2003 and 2004 who are reported to the ABDR as affected by maternal alcohol use. The ABDR coordinator will continue to represent birth defects prevention efforts at the preconception and perinatal health committees.

The perinatal nurse consultant will continue to distribute WCFH-published data and other selected materials, including those on FASD prevention. A revision of the Healthy Mother, Healthy Baby Diary, that includes FASD prevention information, will get into full swing in the coming year, in anticipation of a reprinting.

The perinatal advisory committee will meet later in the year. Tentatively, FASD will be the focus of the spring 2011 meeting. The consultant will continue to pursue options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education on FASD.

As March of Dimes recently finally filled their long-vacant director of program services position, the perinatal nurse consultant hopes to collaborate on projects of mutual interest. The popular Alaska folic acid pamphlet that was originally developed jointly with March of Dimes is due to be revised and reprinted and would be a fitting collaborative project related to the prevention of birth defects.

A major focus of the coming year is completion of the grant process for the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting Program, conducting the needs assessment, and, presumably, beginning of program implementation. It is hoped Alaska can incorporate a strong component related to alcohol prevention, referral, and treatment.

Other possibilities include: partnering with Alaska Division of Behavioral Health to distribute FASD materials and recognize Birth Defects Prevention Month in January; working with the Anchorage FASD coalition to promote and recognize FAS Awareness Day in September; and exploring options to support expanding early prenatal care referral at facilities that provide pregnancy testing and at pregnancy test point of purchase, including advice to avoid alcohol, tobacco and other substances.

**State Performance Measure 9:** *Percentage of infants who are reported to have a Cleft Lip/Palate defect who access the Title V sponsored Cleft Lip and Palate Specialty Clinic within the first year of life.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 26 | 27 | 28 | 29 |
| Annual Indicator | 29.2 | 28.4 | | | |
| Numerator | 21 | 21 | | | |
| Denominator | 72 | 74 | | | |
| Data Source | | | | | |
| Is the Data Provisional or Final? | | | | | |
| | **2010** | **2011** | **2012** | **2013** | **2014** |
| Annual Performance Objective | 30 | 30 | 30 | 30 | |

**Notes - 2009**

Data wasnot evaluated for this state performance measure for this year's submission. We are re-evaluating the usefulness of this indicator as a measure effectiveness of our CLP referral process.

Some families do not participate in state-sponsored Cleft Lip and Palate Specialty Clinics even though they have been referred to the clinics. Instead they choose to seek medical care out of state for a variety of reasons (to be near extended family, to access a Craniofacial center closer to their homes than the nearest state-sponsored clinic, to remain within the military healthcare system, or to address other major health problems that cannot be treated at facilities within the state). In addition some children who have cleft palates in conjunction with other life-threatening conditions do not survive long enough to participate in state-sponsored clinics.

**Notes - 2008**
Data wasnot been evaluated for this state performance measure for this year's submission. We are re-evaluating the usefulness of this indicator as a measure effectiveness of our CLP referral process.

Some families do not participate in state-sponsored Cleft Lip and Palate Specialty Clinics even though they have been referred to the clinics. Instead they choose to seek medical care out of state for a variety of reasons (to be near extended family, to access a Craniofacial center closer to their homes than the nearest state-sponsored clinic, to remain within the military healthcare system, or to address other major health problems that cannot be treated at facilities within the state). In addition some children who have cleft palates in conjunction with other life-threatening conditions do not survive long enough to participate in state-sponsored clinics.

**Notes - 2007**
Data wasnot evaluated for this state performance measure for this year's submission. We are re-evaluating the usefulness of this indicator as a measure effectiveness of our CLP referral process.

Some families do not participate in state-sponsored Cleft Lip and Palate Specialty Clinics even though they have been referred to the clinics. Instead they choose to seek medical care out of state for a variety of reasons (to be near extended family, to access a Craniofacial center closer to their homes than the nearest state-sponsored clinic, to remain within the military healthcare system, or to address other major health problems that cannot be treated at facilities within the state). In addition some children who have cleft palates in conjunction with other life-threatening conditions do not survive long enough to participate in state-sponsored clinics.

**a. Last Year's Accomplishments**
Cleft Lip and Palate (CL/P) Clinics continued in Anchorage and Fairbanks. Four clinics were held in Anchorage and three in Fairbanks. Anchorage clinics were coordinated by the state Section of Women's, Children's and Family Health, and Fairbanks clinics were coordinated by the Section of Public Health Nursing. No clinic was held in Bethel because the need is very small; it was decided that the clinic would be held on an as-needed basis because the few families from the Bethel area preferred to travel to Anchorage for CL/P clinic because of other health services that they needed.

Anchorage clinics were held at the Alaska Native Medical Center (ANMC) through a Memorandum of Agreement between the state and Southcentral Foundation (SCF), an Alaska Native-owned healthcare corporation. After many years of one-year agreements, SCF and the state signed a three-year agreement that assures clinics will be held at ANMC through FY10. ANMC providers were interested in housing the clinics at their facility because approximately half of the children who received evaluations at the state-sponsored clinics were their beneficiaries. Fairbanks clinics were held at the Fairbanks Public Health Center as they have been for many years.

A multidisciplinary team provided patient evaluations. Team members included an audiologist, dietitian, oral surgeon, orthodontist, otolaryngologist, pediatric dentist, pediatrician, plastic surgeon and speech pathologist. In Anchorage and Fairbanks providers from the community volunteered their time and expertise to provide patient evaluations.

A parent navigator from Stone Soup Group (SSG) participated in all clinics and was available to meet with families who requested her services. Her role was to link parents to resources and improve follow-through of treatment plans to assure optimal outcomes. In addition the parent navigator met with parents of newborns at hospitals before discharge and was available to work with parents of cleft-affected children as needed. She wrote a semi-annual newsletter for parents. Parent navigation services were supported by a grant to Stone Soup Group from the state. The parent navigator averaged eight hours of work per week under the grant.

In an effort to increase capacity, provider training was offered at Anchorage clinics. Pediatric dentistry residents, general dentistry residents, a dietitian and a speech pathologist observed at clinics and shadowed team members from their specialty. They gained an understanding of the special needs of children with orofacial clefts and the importance of a multidisciplinary approach to treatment.

During FY2009 125 children received evaluations at state-sponsored CL/P Clinics. Of these, 14 were new patients who were less than a year old. Most newborn referrals were made by hospitals and/or physicians. In rare instances the parent of a cleft-affected newborn self-referred. There are concerns that some newborns with orofacial clefts are not being referred to state-sponsored CL/P Clinics.

In a collaborative effort to assure that all patients and families are referred and given an opportunity to attend clinics, State of Alaska specialty clinic staff and the birth defects registry staff worked on a system for sharing and comparing data. In addition, SSG staff kept a list of all cleft-affected newborns that are referred to them. Through a family release of information, data was compared for a more accurate number.

The state Oral Health Program donated a limited number of spin brushes to CL/P clinics. A pediatric dentist determines which children would most benefit from having the brushes, and those children receive a brush at their clinic visit.

All of these activities were supported by the MCH Block Grant.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Collaborate with the Alaska Native Medical Center to continue leasing their dental space in the outpatient clinic as a site for four Anchorage-based clinics per year. | | | | X |
| 2. Continue to collaborate with Bethel health care providers and assure that all newborns/children with clefts are referred to the Anchorage based clinics and have an ongoing treatment plan. | | X | | |
| 3. Continue grant with Stone Soup Group for parent navigation services. | | X | | |
| 4. Work with public health nurses/tribal organizations to assure that families throughout the state have access to clinic services. | | | X | |
| 5. Continue providing support to Fairbanks public health center staff and the Cleft Palate Clinic team as needed. | | | | X |
| 6. Work with Birth Defects Registry to assure cleft-affected | | | | X |

| | | | | |
|---|---|---|---|---|
| infants are referred to clinics within the first year of life. | | | | |
| 7. Provide opportunities for health care professionals to acquire expertise in treating children with orofacial clefts. | | | | X |
| 8. Expand the numbers of hospitals parent navigation services are offered for babies born with cleft lip and palate to assure referral for parent navigation services within one month of life. | | X | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Activities conducted last year continue in the current year.

Clinic visits for the CL/P clinic for FY10 numbered 126. The number of new patients who were less than one-year old is 22. This is an increase from last year and is the result of improved collaboration of data sharing with the State of Alaska Birth Defects Registry, CL/P clinic, and the SSG staff.

We are working with case managers and other staffers at both the SCF and the ANMC to form a committee to improve communication within the ANMC system to assist families as they navigate through the ANMC health care system. The intent is to assist in pro-actively managing patients' CL/P treatment plans as prescribed by the State of Alaska Clinic. The goal is to better serve the Alaska Native populations.

The state Oral Health Program is donating a limited number of spin brushes to C/LP clinics. A pediatric dentist determines which children would most benefit from having the brushes, and those children receive a brush at their clinic visit.

**c. Plan for the Coming Year**
Work will continue to assure that state-sponsored CL/P clinics are easily accessible to families throughout Alaska. Clinics will be held in Anchorage and Fairbanks. Bethel families will continue to be invited to attend the Anchorage clinics.

As providers retire or relinquish their positions on the team, we are planning to bring on new team members to assure there is experienced staff capacity in the community. To assure each specialty will have staff, several new members are being added to the team and will participate in clinics throughout the year. This will also assist the team in assuring back-up and on-going training. Providers continue to volunteer for this clinical team.

The State of Alaska clinic staff continues to partner with the SCF/ANMC committee which is working to assist families and providers in follow-up with treatment recommended by the CL/P team. An example of one of this committee's efforts is to improve access to comprehensive and accurate records for Alaskan native families. Families often visit multiple locations and clinics; as a result, complete records become fragmented, challenging both families and providers. The committee is actively working on easing the document system.

Additionally, newborn data will be compared between the State of Alaska Birth Defect Registry and SSG to determine if all newborns with orofacial clefts are being referred to state-sponsored clinics. If families are identified that were not referred to clinic, SSG staff will work to educate the primary care provider. SSG staff will continue to visit major hospitals where newborns with CL/P are; the nursing staff will receive an orientation type in-service on available services. In addition, the SSG staff hopes to conduct a presentation at a weekly Anchorage and Fairbanks pediatric grand round meeting.

These are direct health care and infrastructure-building services.

## E. Health Status Indicators

**Introduction**

Many of the HSI indicators are reported in the MCH Data Books published by the MCH Epidemiology Unit every two years. Every third year the Data Book features a comprehensive look at maternal and child health indicators. In interim years, Data Books focus on specific MCH topics, presenting the findings of public health surveillance programs operated by the MCH Epidemiology Unit. Previous Data Books covered data from PRAMS and data from the Alaska Birth Defects Registry. The next Data Book will focus on health status indicators for the Alaska Native population, in collaboration with the ANTHC EpiCenter. The data books are available online at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/default.htm.

The MCH Epidemiology Unit also publishes the Special Series Fact Sheets are a set of 42 condensed fact sheets addressing prevalence, trends, comparisons to the national baseline, disparities, and interventions and recommendations on a variety of health topics. The fact sheets are online at http://www.epi.hss.state.ak.us/mchepi/MCHFacts/na.htm.

There are no barriers to accessing any of the HSI data.

### Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Indicator | 6.0 | 5.9 | 5.7 | 6.0 | |
| Numerator | 630 | 652 | 623 | 682 | |
| Denominator | 10415 | 10958 | 11007 | 11416 | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |

**Notes - 2009**

Source: AK Bureau of Vital Statistics. The latest available data is for 2008.

**Notes - 2008**

Source: AK Bureau of Vital Statistics. The latest available data is for 2008.

**Notes - 2007**

Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

**Narrative:**

The trend for proportion of low birthweight, and very low birthweight for all and singleton births has remained stable since 2000. In 2007 the Anchorage/MatSu region had the highest percentage of low birthweight among singleton births. This region is where almost 2/3 of the

deliveries occur. The Northern and Southwest regions had the highest percent of preterm births during 2001 - 2005. Prevention of unintended pregnancy and reduction in smoking, other tobacco use, alcohol and other illicit drugs during pregnancy may improve birth outcomes. Prenatal tobacco use, including cigarettes, smokeless tobacco and iq'mik (spit tobacco) is tracked through PRAMS. Women with high risk pregnancies are generally referred to tertiary care centers. Gains in reductions of preterm births in the Alaska Native population have occurred during the time the Indian Health Service has had a perinatologist on staff at the Alaska Medical Center for the last few years. With his departure in calendar year 2008, it will be interesting to see if the progress made over the years he has been in the state changes. In addition, the state lost a second private sector perinatologist leaving the state with only one for the entire state.

**Health Status Indicators 01B:** *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 4.7 | 4.7 | 4.2 | 4.6 | |
| Numerator | 481 | 502 | 449 | 506 | |
| Denominator | 10147 | 10649 | 10699 | 11063 | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |

**Notes - 2009**
Source: AK Bureau of Vital Statistics. The latest available data is for 2008.

**Notes - 2008**
Source: AK Bureau of Vital Statistics. The latest available data is for 2008.

**Notes - 2007**
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

**Narrative:**
The trend for proportion of low birthweight, and very low birthweight for all and singleton births has remained stable since 2000. In 2007 the Anchorage/MatSu region had the highest percentage of low birthweight among singleton births. This region is where almost 2/3 of the deliveries occur. The Northern and Southwest regions had the highest percent of preterm births during 2001 - 2005. Prevention of unintended pregnancy and reduction in smoking, other tobacco use, alcohol and other illicit drugs during pregnancy may improve birth outcomes. Prenatal tobacco use, including cigarettes, smokeless tobacco and iq'mik (spit tobacco) is tracked through PRAMS. Women with high risk pregnancies are generally referred to tertiary care centers. Gains in reductions of preterm births in the Alaska Native population have occurred during the time the Indian Health Service has had a perinatologist on staff at the Alaska Medical Center for the last few years. With his departure in calendar year 2008, it will be interesting to see if the progress made over the years he has been in the state changes. In addition, the state lost a second private sector perinatologist leaving the state with only one for the entire state.

**Health Status Indicators 02A:** *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Indicator | 0.9 | 1.1 | 0.9 | 1.0 | |
| Numerator | 95 | 123 | 99 | 114 | |
| Denominator | 10415 | 10958 | 11007 | 11416 | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |

**Notes - 2009**
Source: AK Bureau of Vital Statistics. The latest available data is for 2008.

**Notes - 2008**
Source: AK Bureau of Vital Statistics. The latest available data is for 2008.
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**Notes - 2007**
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

**Narrative:**
The trend for proportion of low birthweight, and very low birthweight for all and singleton births has remained stable since 2000. In 2007 the Anchorage/MatSu region had the highest percentage of low birthweight among singleton births. This region is where almost 2/3 of the deliveries occur. The Northern and Southwest regions had the highest percent of preterm births during 2001 - 2005. Prevention of unintended pregnancy and reduction in smoking, other tobacco use, alcohol and other illicit drugs during pregnancy may improve birth outcomes. Prenatal tobacco use, including cigarettes, smokeless tobacco and iq'mik (spit tobacco) is tracked through PRAMS. Women with high risk pregnancies are generally referred to tertiary care centers. Gains in reductions of preterm births in the Alaska Native population have occurred during the time the Indian Health Service has had a perinatologist on staff at the Alaska Medical Center for the last few years. With his departure in calendar year 2008, it will be interesting to see if the progress made over the years he has been in the state changes. In addition, the state lost a second private sector perinatologist leaving the state with only one for the entire state.

**Health Status Indicators 02B:** *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Indicator | 0.8 | 0.9 | 0.6 | 0.8 | |
| Numerator | 80 | 96 | 66 | 85 | |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | 10147 | 10649 | 10699 | 11063 | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |

**Notes - 2009**
Source: AK Bureau of Vital Statistics. The latest available data is for 2008.

**Notes - 2008**
Source: AK Bureau of Vital Statistics. The latest available data is for 2008.

**Notes - 2007**
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

**Narrative:**
The trend for proportion of low birthweight, and very low birthweight for all and singleton births has remained stable since 2000. In 2007 the Anchorage/MatSu region had the highest percentage of low birthweight among singleton births. This region is where almost 2/3 of the deliveries occur. The Northern and Southwest regions had the highest percent of preterm births during 2001 - 2005. Prevention of unintended pregnancy and reduction in smoking, other tobacco use, alcohol and other illicit drugs during pregnancy may improve birth outcomes. Prenatal tobacco use, including cigarettes, smokeless tobacco and iq'mik (spit tobacco) is tracked through PRAMS. Women with high risk pregnancies are generally referred to tertiary care centers. Gains in reductions of preterm births in the Alaska Native population have occurred during the time the Indian Health Service has had a perinatologist on staff at the Alaska Medical Center for the last few years. With his departure in calendar year 2008, it will be interesting to see if the progress made over the years he has been in the state changes. In addition, the state lost a second private sector perinatologist leaving the state with only one for the entire state.

**Health Status Indicators 03A:** *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 19.1 | 19.4 | 20.1 | 18.5 | |
| Numerator | 92 | 93 | 97 | 90 | |
| Denominator | 480546 | 480464 | 482503 | 486703 | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |

**Notes - 2009**

Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2008 covers 2006 - 2008. The latest available data is 2006-2008.

**Notes - 2008**
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2008 covers 2006 - 2008. The latest available data is 2006-2008.

**Notes - 2007**
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2007 covers 2005 - 2007. The latest available data is 2005-2007.

**Narrative:**
Unintentional injury is the leading cause of mortality among all children in Alaska and the nation. Alaskans frequently participate in activities that could put children at risk for unintentional injury. The Childhood Understanding Behaviors Survey surveillance program tracks risk factors. Fifty-nine percent of Alaska two-year olds in 2006 had ridden in a boat since birth and 18% rode on, or were pulled in a trailer behind, an ATV or snow machine during the past week. The second leading cause of unintentional injury among adolescents is drowning. This type of information can be used for targeted messaging.

In FY 2010, the Section of Injury Prevention and Emergency Medical Services (IPEMS) was dissolved. Injury prevention programs were moved to the Section of Chronic Disease Prevention and Health Promotion (CDPHP). Two examples of injury prevention programs are:

- The Alaska Kids Don't Float program is aimed at preventing drowning, the second leading cause of mortality among children under 14. The program includes a personal floatation device loaner program for use at harbors and boat ramps, water safety 'train the trainers' education for high school students, and public education throughout the state of Alaska with a focus in high use areas and rural river systems used for transportation in bush Alaska.

- An injury prevention home visitation program. The objective is to educate home visiting groups of unintentional injuries and related hazards in the home, then train the home visitors to perform home safety reviews, provide home safety education, and install safety devices to high-risk households. Training is provided to any interested groups, such as Head Start, or Village Health Aides, on home safety inspections and the installation of safety devices.

CDPHP partners with the Safe Kids Alaska on a variety of events such as car seat checkups, Safe Routes to School, and Safety Bear.

In FY 2010 the Child Death Review (CDR) program re-established reviews of child mortality for children 14 years and younger. Multiple data sources including death certificates, Medicaid records where available, and law enforcement reports will be used to obtain a committee consensus on cause of death.

**Health Status Indicators 03B:** *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 6.5 | 5.0 | 4.1 | 3.9 | |
| Numerator | 31 | 24 | 20 | 19 | |
| Denominator | 480546 | 480464 | 482503 | 486703 | |
| Check this box if you cannot report the numerator | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | | |

**Notes - 2009**
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2008 covers 2006 - 2008. The latest available data is 2006-2008.

**Notes - 2008**
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2008 covers 2006 - 2008. The latest available data is 2006-2008.

**Notes - 2007**
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2007 covers 2005 - 2007. The latest available data is 2005-2007.

**Narrative:**
The unintentional injury mortality rate for children < 14 years due to motor vehicle crashes dropped for the third year in a row (based on 3-year moving averages). The Child Passenger Safety Program, implemented by Section of Chronic Disease Prevention and Health Promotion (CDPHP) (http://www.hss.state.ak.us/dph/ipems/injury_prevention/CPS/default.htm) offers information on safety restraints, legislation, and other programs in Alaska.

In 2009 the legislature passed new legislation requiring the use of booster seats for young children and clarified the use of child passenger restraints based on the national standards. This will hopefully make the management of these information to the public more easily understood and will assist law enforcement with enforcing the laws. The challenge is that there are many motor vehicle deaths in the rural parts of the state where child passenger safety seats are not used due to alternative methods of travel such as three and four wheelers. Ongoing education and modeling by adults is needed in order to change long standing behaviors.

**Health Status Indicators 03C:** *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 26.9 | 21.6 | 24.9 | 25.1 | |
| Numerator | 78 | 64 | 75 | 76 | |
| Denominator | 290239 | 296409 | 301774 | 302886 | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |

**Notes - 2009**

Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2008 covers 2006 - 2008. The latest available data is 2006-2008.

**Notes - 2008**
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2008 covers 2006 - 2008. The latest available data is 2006-2008.

**Notes - 2007**
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2007 covers 2005 - 2007. The latest available data is 2005-2007.

**Narrative:**
In the last decade, approximately 42% of deaths among Alaskan teens were due to unintentional injury, with more than half of those caused by motor vehicle crashes.

Effective January 1, 2005, drivers under 18 years of age may only have a provisional license with proof of 40 hours of driving experience, including 10 in challenging conditions. Provisional license drivers may not carry passengers under the age of 21, except siblings, and may not operate a motor vehicle between 1:00 am and 5: 00 am, unless accompanied by an adult over 21 or driving to work. This law has helped to reduce some of the injuries of children in this age group in the urban areas of the state, however has not necessarily impacted areas of the state where alternative vehicles are used for transportation on dirt roads, trails, and snow machine trails. It is common for young children to operate 3 and 4 wheelers without helmets or adults accompanying them in rural parts of state. Ongoing education and appropriate modeling and supervision by adults is needed to change these behaviors.

**Health Status Indicators 04A:** *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 338.8 | 303.4 | 359.6 | 417.1 | |
| Numerator | 543 | 486 | 581 | 674 | |
| Denominator | 160249 | 160168 | 161580 | 161580 | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Notes - 2009**
/2011/ There is no data for 2008 or 2009. It was discovered that data for 2007 was entered incorrectly and data for one large Anchorage hospital was missing. Data is being re-entered, matched, and corrected for 2007 and 2008. Limited staff resources means that 2007 - 2009 data may not be available to report until the FY 2012 application.

**Notes - 2008**

Source: AK Trauma Registry. There is no data for 2008 or 2009. It was discovered that data for 2007 was entered incorrectly and data for one large Anchorage hospital was missing. Data is being re-entered, matched, and corrected for 2007 and 2008. Limited staff resources means that 2007 - 2008 data may not be available to report until the FY 2012 application.

**Notes - 2007**
Source: AK Trauma Registry. The latest available data is for 2007.
HSI 4A is calculated using all nonfatal unintentional hospitalized injuries for children 14 years old or younger. Ecode < 950.0

/2011/ In 2009 major data entry errors in the Trauma Registry were discovered. By August 2010, CY 2007 data were cleaned and the block grant indicator was revised (9/15/2010). CY 2008 data is in the process of being cleaned and corrected as of September 2010.

**Narrative:**
Unintentional injury is the leading cause of mortality among all children in Alaska and the nation. Alaskans frequently participate in activities that could put children at risk for unintentional injury. The Childhood Understanding Behaviors Survey surveillance program tracks risk factors. Fifty-nine percent of Alaska two-year olds in 2006 had ridden in a boat since birth and 18% rode on, or were pulled in a trailer behind, an ATV or snow machine during the past week. The second leading cause of unintentional injury among adolescents is drowning. This type of information can be used for targeted messaging and education.

Injury prevention programs are implemented by the Division of Public Health, Section of Chronic Disease Prevention and Health Promotion (CDPHP). Three examples are:

- # The Alaska Kids Don't Float program is aimed at preventing drowning, the second leading cause of mortality among children under 14. The program includes a personal floatation device loaner program for use at harbors and boat ramps, water safety 'train the trainers' education for high school students, and public education.

- # An injury prevention home visitation program. The objective is to educate home visiting groups of unintentional injuries and related hazards in the home, then train the home visitors to perform home safety reviews, provide home safety education, and install safety devices to high-risk households. Training is provided to any interested groups, such as Head Start, or Village Health Aides, on home safety inspections and the installation of safety devices.

- Bike helmet safety is also a heavily promoted intervention with the Safe Kids Alaska sites hosting annual bike rodeos every spring/summer to promote bicycle safety and helmet usage. Finally, helmet usage by children on snow machines has been promoted annually in the larger rural communities who depend upon snow machines for transportation.

CDPHP partners with the Safe Kids Alaska on a variety of events such as car seat checkups, Safe Routes to School, and Safety Bear.

**Health Status Indicators 04B:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 15.0 | 5.6 | 21.0 | 22.9 | |
| Numerator | 24 | 9 | 34 | 37 | |
| Denominator | 160249 | 160168 | 161580 | 161580 | |

| | | | | | |
|---|---|---|---|---|---|
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | |

**Notes - 2009**
Source: Trauma Registry. 2008 data is an estimate based on 2007. There is no data for 2008 or 2009. In addition, it was discovered that data for 2007 was entered incorrectly and data for one large Anchorage hospital was missing. Data is being re-entered, matched, and corrected for 2007 and 2008. Limited staff resources means that 2007 - 2008 data may not be available to report until the FY 2012 application.

**Notes - 2008**
Source: AK Trauma Registry. 2008 data is an estimate based on 2007. There is no data for 2008 or 2009. In addition, it was discovered that data for 2007 was entered incorrectly and data for one large Anchorage hospital was missing. Data is being re-entered, matched, and corrected for 2007 and 2008. Limited staff resources means that 2007 - 2008 data may not be available to report until the FY 2012 application.

**Notes - 2007**
Source: AK Trauma Registry. The latest available data is for 2007.
HSI 4B is calculated using hospitalizations for nonfatal injuries due to motor vehicle crashes on the highway incl. bike and pedestrian vs motor vehicles: ecodes 810.0 - 819.9

/2011/ In 2009 major data entry errors in the Trauma Registry were discovered. By August 2010, CY 2007 data were cleaned and the block grant indicator was revised (9/15/2010). CY 2008 data is in the process of being cleaned and corrected as of September 2010.

**Narrative:**
The Child Passenger Safety Program, implemented by CDPHP (http://www.hss.state.ak.us/dph/ipems/injury_prevention/CPS/default.htm) offers information on safety restraints, legislation, and other programs in Alaska. The 2008 Alaska State Legislature amended an existing law relating to use of child safety seats and seat belts to be more specific about using age, height and weight appropriate safety equipment. The law is effective 9/1/2009. CDPHP offers ongoing child passenger safety seat training across the state and has developed a core group of highly experienced trainers located in several communities across the state including some of the larger rural communities. The web site offers information on choosing the correct size of safety seat for children and other information on installation and safety features on various brands of car seats/booster seats.

**Health Status Indicators 04C:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 54.8 | 12.9 | 161.0 | 161.0 | |
| Numerator | 54 | 13 | 164 | 164 | |
| Denominator | 98630 | 101010 | 101862 | 101862 | |
| Check this box if you cannot report the numerator because | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | |

**Notes - 2009**
Source: AK Trauma Registry.

2008 data is an estimate based on 2007. There is no data for 2008 or 2009. In addition, it was discovered that data for 2007 was entered incorrectly and data for one large Anchorage hospital was missing. Data is being re-entered, matched, and corrected for 2007 and 2008. Limited staff resources means that 2007 - 2008 data may not be available to report until the FY 2012 application.

**Notes - 2008**
Source: AK Trauma Registry. 2008 data is an estimate based on 2007. There is no data for 2008 or 2009. In addition, it was discovered that data for 2007 was entered incorrectly and data for one large Anchorage hospital was missing. Data is being re-entered, matched, and corrected for 2007 and 2008. Limited staff resources means that 2007 - 2008 data may not be available to report until the FY 2012 application.

**Notes - 2007**
Source: AK Trauma Registry. The latest available data is for 2007.

Although the indicator reported for 2007 looks to be in error because of the magnitude of the difference from 2005 and 2006, actually the latter two years were the anamoly. Rates for 2000 through 2004 were: 166.3, 209.1, 182.0, 192.0, and 176.5.

**Narrative:**
Effective January 1, 2005, drivers under 18 years of age may only have a provisional license with proof of 40 hours of driving experience, including 10 in challenging conditions. Provisional license drivers may not carry passengers under the age of 21, except siblings, and may not operate a motor vehicle between 1:00 am and 5: 00 am, unless accompanied by an adult over 21 or driving to work.

**Health Status Indicators 05A:** *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 41.4 | 40.8 | 42.1 | 39.9 | 34.5 |
| Numerator | 1084 | 1105 | 1138 | 1080 | 926 |
| Denominator | 26177 | 27057 | 27017 | 27042 | 26817 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**

Source: AK DHSS, Section of Epidemiology

**Notes - 2008**
Source: AK DHSS, Section of Epidemiology

**Notes - 2007**
Source: AK Section of Epidemiology

**Narrative:**
Alaska has had the first or second highest Chlamydia trachomatis (CT) infection rate in the United States each year since 2000. In 2009, the highest documented CT infection rates by sex and age were among females aged 20--24 years at 6,370 cases per 100,000 females, and males aged 20--24 years at 3,200 cases per 100,000 males.

A total of 5,253 cases of CT infection were reported in Alaska in 2009; this represents an 8% increase from the 4,869 CT cases reported in 2008. In 2009, the CT infection rate in Alaska was nearly two times higher than the 2008 CT infection rate in the United States. Alaskan women, adolescents and young adults, and racial minority groups are disproportionally impacted by chlamydia.

The state's STD Program consists of case surveillance, consultation on laboratory and medical aspects of diagnosis and treatment; direct assistance to providers in outbreak situations; assistance to affected individuals and their sexual partners, as well as to their health care providers, with partner notification and access to STD treatment; training for health care providers in partner interviewing, follow up, notification, and referral techniques; and provision of information, technical assistance, and other capacity building services to medical and other health service providers, as well as educators and members of the public. The Title V program actively participates in the Infertility Prevention project as a part of the Title X Family Planning to promote prevention of sexually transmitted infections, access to testing both the client and any partner contacts as well as just in time treatment.

The 2009 chlamydia report is available at
http://www.epi.hss.state.ak.us/bulletins/docs/b2010_19.pdf.

**Health Status Indicators 05B:** *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2005** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|---|
| Annual Indicator | 15.3 | 16.4 | 18.2 | 18.2 | 21.2 |
| Numerator | 1750 | 1872 | 2075 | 2074 | 2432 |
| Denominator | 114034 | 113850 | 113793 | 113738 | 114848 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2009**
Source: AK DHSS, Section of Epidemiology

**Notes - 2008**
Source: AK DHSS, Section of Epidemiology

**Notes - 2007**
Source: AK Section of Epidemiology

**Narrative:**
Alaska has had the first or second highest Chlamydia trachomatis (CT) infection rate in the United States each year since 2000. In 2009, the highest documented CT infection rates by sex and age were among females aged 20--24 years at 6,370 cases per 100,000 females, and males aged 20--24 years at 3,200 cases per 100,000 males.

A total of 5,253 cases of CT infection were reported in Alaska in 2009; this represents an 8% increase from the 4,869 CT cases reported in 2008. In 2009, the CT infection rate in Alaska was nearly two times higher than the 2008 CT infection rate in the United States. Alaskan women, adolescents and young adults, and racial minority groups are disproportionally impacted by chlamydia.

The state's STD Program consists of case surveillance, consultation on laboratory and medical aspects of diagnosis and treatment; direct assistance to providers in outbreak situations; assistance to affected individuals and their sexual partners, as well as to their health care providers, with partner notification and access to STD treatment; training for health care providers in partner interviewing, follow up, notification, and referral techniques; and provision of information, technical assistance, and other capacity building services to medical and other health service providers, as well as educators and members of the public. The Title V program actively participates in the Infertility Prevention project as a part of the Title X Family Planning to promote prevention of sexually transmitted infections, access to testing both the client and any partner contacts as well as just in time treatment.

The 2009 chlamydia report is available at
http://www.epi.hss.state.ak.us/bulletins/docs/b2010_19.pdf.

## Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

| **CATEGORY** TOTAL POPULATION BY RACE | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Infants 0 to 1 | 11400 | 6426 | 405 | 2412 | 498 | 116 | 1543 | 0 |
| Children 1 through 4 | 44837 | 26688 | 1464 | 9214 | 1760 | 395 | 5316 | 0 |
| Children 5 through 9 | 54175 | 34634 | 2130 | 10030 | 2003 | 365 | 5013 | 0 |
| Children 10 through 14 | 52666 | 34270 | 2120 | 9656 | 2100 | 374 | 4146 | 0 |
| Children 15 through 19 | 55013 | 35438 | 1953 | 11086 | 2120 | 437 | 3979 | 0 |
| Children 20 through 24 | 45446 | 27632 | 2522 | 9705 | 1927 | 382 | 3278 | 0 |
| Children 0 through 24 | 263537 | 165088 | 10594 | 52103 | 10408 | 2069 | 23275 | 0 |

**Notes - 2011**

**Narrative:**
Alaska Native children compose the largest minority among children 0 -- 24 years of age, at 20%. Alaska Native children represent 23% of all infants under 1 year. African-American and Hispanic children together make up 10% of the 0-24 age group.

Population estimates by race and age are made annually by the AK Department of Labor and Workforce Development.

**Health Status Indicators 06B:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

| **CATEGORY** TOTAL POPULATION BY HISPANIC ETHNICITY | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Infants 0 to 1 | 10640 | 760 | 0 |
| Children 1 through 4 | 41880 | 2957 | 0 |
| Children 5 through 9 | 51014 | 3161 | 0 |
| Children 10 through 14 | 50088 | 2578 | 0 |
| Children 15 through 19 | 52786 | 2227 | 0 |
| Children 20 through 24 | 43121 | 2325 | 0 |
| Children 0 through 24 | 249529 | 14008 | 0 |

**Notes - 2011**

**Narrative:**
Alaska Native children compose the largest minority among children 0 -- 24 years of age, at 20%. Alaska Native children represent 23% of all infants under 1 year. African-American and Hispanic children together make up 10% of the 0-24 age group.

Population estimates by race and age are made annually by the AK Department of Labor and Workforce Development.

**Health Status Indicators 07A:** *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

| **CATEGORY** Total live births | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Women < 15 | 5 | 1 | 0 | 4 | 0 | 0 | 0 | 0 |
| Women 15 through 17 | 301 | 108 | 18 | 148 | 22 | 2 | 0 | 3 |
| Women 18 through 19 | 833 | 379 | 35 | 352 | 54 | 6 | 0 | 7 |
| Women 20 through 34 | 8916 | 5622 | 326 | 2159 | 680 | 34 | 0 | 95 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Women 35 or older | 1373 | 942 | 43 | 227 | 140 | 2 | 0 | 19 |
| Women of all ages | 11428 | 7052 | 422 | 2890 | 896 | 44 | 0 | 124 |

**Notes - 2011**

**Narrative:**
In 2007, the highest birth rates were among women 25 - 29 years (154.2 per 1,000 female population), followed by 20 - 24 (144.1) and 30 - 34 (94.3). Program staff collaborated with the Division of Public Assistance in providing long acting reversible contraceptives in western Alaska, the region with the highest rate of teen births and non-marital births. These monies have also supported Title V staff in providing education, training and supplies to rural providers on insertion of long acting reversible contraceptives, education on other methods and approaches to family planning education especially for the rural tribal health aides.

The Perinatal Advisory Committee and the newly formed Preconception Advisory Committee, staffed by WCFH and other staff from the Division of Public Health, meet on a regular basis to address issues, needs, and programs.

There is a relatively small Hispanic population in Alaska. The primary criteria for identifying racial disparity is Alaska Native status. Numbers for other minority groups are too small for analysis purposes.

**Health Status Indicators 07B:** *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

| **CATEGORY** Total live births | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Women < 15 | 4 | 0 | 1 |
| Women 15 through 17 | 271 | 27 | 3 |
| Women 18 through 19 | 778 | 45 | 10 |
| Women 20 through 34 | 8343 | 504 | 69 |
| Women 35 or older | 1303 | 64 | 6 |
| Women of all ages | 10699 | 640 | 89 |

**Notes - 2011**

**Narrative:**
In 2007, the highest birth rates were among women 25 - 29 years (154.2 per 1,000 female population), followed by 20 - 24 (144.1) and 30 - 34 (94.3). Program staff collaborated with the Division of Public Assistance in providing long acting reversible contraceptives in western Alaska, the region with the highest rate of teen births and non-marital births. These monies have also supported Title V staff in providing education, training and supplies to rural providers on insertion of long acting reversible contraceptives, education on other methods and approaches to family planning education especially for the rural tribal health aides.

The Perinatal Advisory Committee and the newly formed Preconception Advisory Committee, staffed by WCFH and other staff from the Division of Public Health, meet on a regular basis to address issues, needs, and programs.

There is a relatively small Hispanic population in Alaska. The primary criteria for identifying racial disparity is Alaska Native status. Numbers for other minority groups are too small for analysis purposes.

**Health Status Indicators 08A:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

| **CATEGORY** Total deaths | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Infants 0 to 1 | 67 | 22 | 4 | 35 | 5 | 1 | 0 | 0 |
| Children 1 through 4 | 20 | 12 | 0 | 8 | 0 | 0 | 0 | 0 |
| Children 5 through 9 | 8 | 5 | 0 | 2 | 1 | 0 | 0 | 0 |
| Children 10 through 14 | 14 | 5 | 0 | 9 | 0 | 0 | 0 | 0 |
| Children 15 through 19 | 45 | 23 | 1 | 21 | 0 | 0 | 0 | 0 |
| Children 20 through 24 | 64 | 34 | 2 | 27 | 0 | 0 | 0 | 1 |
| Children 0 through 24 | 218 | 101 | 7 | 102 | 6 | 1 | 0 | 1 |

**Notes - 2011**

**Narrative:**
The Alaska Maternal Infant Mortality Review (MIMR) has existed since 1991 and is managed by the MCH Epidemiology Unit. Data from the MIMR has enabled research projects that resulted in continued improvements to the public health care system. During the fifteen year period from 1990 to 2004, post-neonatal mortality decreased by 37% and neonatal mortality decreased by 32%. MIMR data was used to implement a Safe Sleep Initiative. Bed sharing, a common practice in Alaska, is an environment frequently involved in infant death. Vital records, medical records, autopsy reports, and first responder reports were analyzed for 93% of Alaskan infant deaths occurring during 1992-2004. Deaths while bed sharing were examined for risk factors including sleeping with a non-caregiver, prone position, maternal tobacco use, impairment of a bed sharing partner, and unsafe sleep surface. The state has established a Safe Sleep Initiative to further clarify its recommendations and target public education messages to families engaging in high risk behaviors. In 2007 the MIMR was expanded to include review of child deaths.

In 2007, the MCH Epidemiology Unit established the Alaska Surveillance of Child Abuse and Neglect (SCAN), an on-going systematic collection and unification of data from up to 9 sources housed in different state agencies. Linking data from a wide variety of sources will allow the state to measure and understand maltreatment-related deaths.

**Health Status Indicators 08B:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

| **CATEGORY** Total deaths | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Infants 0 to 1 | 63 | 3 | 1 |
| Children 1 through 4 | 19 | 0 | 1 |
| Children 5 through 9 | 6 | 2 | 0 |
| Children 10 through 14 | 14 | 0 | 0 |
| Children 15 through 19 | 44 | 1 | 0 |
| Children 20 through 24 | 63 | 1 | 0 |
| Children 0 through 24 | 209 | 7 | 2 |

**Notes - 2011**

**Narrative:**
The Alaska Maternal Infant Mortality Review (MIMR) has existed since 1991 and is managed by the MCH Epidemiology Unit. Data from the MIMR has enabled research projects that resulted in continued improvements to the public health care system. During the fifteen year period from 1990 to 2004, post-neonatal mortality decreased by 37% and neonatal mortality decreased by 32%. MIMR data was used to implement a Safe Sleep Initiative. Bed sharing, a common practice in Alaska, is an environment frequently involved in infant death. Vital records, medical records, autopsy reports, and first responder reports were analyzed for 93% of Alaskan infant deaths occurring during 1992-2004. Deaths while bed sharing were examined for risk factors including sleeping with a non-caregiver, prone position, maternal tobacco use, impairment of a bed sharing partner, and unsafe sleep surface. The state has established a Safe Sleep Initiative to further clarify its recommendations and target public education messages to families engaging in high risk behaviors. In 2007 the MIMR was expanded to include review of child deaths.

In 2007, the MCH Epidemiology Unit established the Alaska Surveillance of Child Abuse and Neglect (SCAN), an on-going systematic collection and unification of data from up to 9 sources housed in different state agencies. Linking data from a wide variety of sources will allow the state to measure and understand maltreatment-related deaths.

**Health Status Indicators 09A:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

| **CATEGORY** Misc Data BY RACE | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** | **Specific Reporting Year** |
|---|---|---|---|---|---|---|---|---|---|
| All children 0 through 19 | 218091 | 137456 | 8072 | 42398 | 8481 | 1687 | 19997 | 0 | 2009 |
| Percent in household headed by | 32.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2008 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| single parent | | | | | | | | | |
| Percent in TANF (Grant) families | 5.2 | 3.4 | 14.6 | 4.4 | 15.9 | 38.6 | 5.6 | 0.0 | 2009 |
| Number enrolled in Medicaid | 81927 | 30728 | 5055 | 34587 | 6152 | 3073 | 0 | 2332 | 2009 |
| Number enrolled in SCHIP | 15650 | 6443 | 859 | 4816 | 1376 | 646 | 0 | 1510 | 2009 |
| Number living in foster home care | 2203 | 587 | 92 | 1249 | 9 | 31 | 187 | 48 | 2009 |
| Number enrolled in food stamp program | 50955 | 15186 | 2509 | 21555 | 3109 | 1956 | 4762 | 1878 | 2009 |
| Number enrolled in WIC | 29346 | 11499 | 1124 | 8215 | 1541 | 1161 | 5796 | 10 | 2009 |
| Rate (per 100,000) of juvenile crime arrests | 2153.7 | 1521.2 | 4744.8 | 3292.6 | 1214.5 | 7231.8 | 1855.3 | 0.0 | 2009 |
| Percentage of high school drop-outs (grade 9 through 12) | 7.0 | 5.3 | 7.7 | 11.5 | 5.1 | 5.1 | 0.0 | 0.0 | 2009 |

**Notes - 2011**
Data source: AK Dept. of Labor. Estimates by race are for race alone, not in combination.

Source: KidsCount, Population and Family Characteristics. Data covers 2008 and is not available by race due to small numbers.

Note: We report "Referrals" rather than "Arrests". A referral is a request by a law enforcement agency for a DJJ response following the arrest of a juvenile or as a result of the submission of a police investigation report alleging the commission of a crime or violation of a court order. A referral is counted as a single episode or event and may relate to multiple charges. Referrals by race is for ages 0 - 18+. The denominator is a count of children 0 - 19. The latest available data for the denominator (children by race category) is for the previous year.

Source: Department of Education and Early Development. Asian and Pacific Islander categories are combined, not counted separately.

Data source: AFCARS Foster Care Submission files. This is a point-in-time count as of 9/30/2009.

**Narrative:**
The Alaska Maternal Child Health Data Book 2008: Health Status Edition was published and disseminated in spring 2009. Wherever possible, indicators in this edition were stratified by Alaska Native racial status and by six geographic regions, to explore racial, urban/rural, and health delivery system differences. New indicators that reflect Alaska-specific issues were included, such as bed sharing, infant discharge from hospital within 48 hours, infant checkup

within 48 hours, and life stressors among women recently delivering a live birth. All the data books are online at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/default.htm

The Section of Women's Children's and Family Health also main a series of 42 Fact Sheets on health status of women, children, and children with special health care needs. These fact sheets are distributed widely to health care providers, legislators, and the general public, and will be used for the Title V Needs Assessment in 2010. They are updated on a regular basis with data from our six surveillance projects and extensive research activities. They are available online at http://www.epi.hss.state.ak.us/mchepi/MCHFacts/na.htm.

**Health Status Indicators 09B:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

| **CATEGORY** Miscellaneous Data BY HISPANIC ETHNICITY | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** | **Specific Reporting Year** |
|---|---|---|---|---|
| All children 0 through 19 | 206408 | 11683 | 0 | 2009 |
| Percent in household headed by single parent | 0.0 | 0.0 | 0.0 | 2008 |
| Percent in TANF (Grant) families | 5.2 | 5.2 | 0.0 | 2009 |
| Number enrolled in Medicaid | 78404 | 3523 | 0 | 2009 |
| Number enrolled in SCHIP | 14614 | 1036 | 0 | 2009 |
| Number living in foster home care | 1864 | 102 | 237 | 2009 |
| Number enrolled in food stamp program | 48984 | 1968 | 0 | 2009 |
| Number enrolled in WIC | 26816 | 2520 | 10 | 2009 |
| Rate (per 100,000) of juvenile crime arrests | 2196.1 | 1403.7 | 0.0 | 2009 |
| Percentage of high school drop-outs (grade 9 through 12) | 7.0 | 6.4 | 0.0 | 2009 |

**Notes - 2011**
There is no data available by Hispanic or Latino ethnicity, due to small numbers.

Source: Department of Education and Early Development. Asian and Pacific Islander categories are not counted separately. Hispanic ethnicity not included in White race category.

**Narrative:**
The Alaska Maternal Child Health Data Book 2008: Health Status Edition was published and disseminated in spring 2009. Wherever possible, indicators in this edition were stratified by Alaska Native racial status and by six geographic regions, to explore racial, urban/rural, and health delivery system differences. New indicators that reflect Alaska-specific issues were included, such as bed sharing, infant discharge from hospital within 48 hours, infant checkup within 48 hours, and life stressors among women recently delivering a live birth. All the data books are online at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/default.htm

The Section of Women's Children's and Family Health also main a series of 42 Fact Sheets on health status of women, children, and children with special health care needs. These fact sheets are distributed widely to health care providers, legislators, and the general public, and will be used for the Title V Needs Assessment in 2010. They are updated on a regular basis with data

from our six surveillance projects and extensive research activities. They are available online at http://www.epi.hss.state.ak.us/mchepi/MCHFacts/na.htm.

**Health Status Indicators 10:** *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

| Geographic Living Area | Total |
|---|---|
| Living in metropolitan areas | 98106 |
| Living in urban areas | 145304 |
| Living in rural areas | 76202 |
| Living in frontier areas | 0 |
| **Total** - all children 0 through 19 | 221506 |

**Notes - 2011**
Population counts in rural/urban areas by age group are not available. Estimates of the urban/rural alloocation from the 2000 census were applied to current population estimate of children 0-19 years. Metropolitan areas in AK are the Municipality of Anchorage and Fairbanks North Star Borough. Population estimates for Frontier areas are included in the population estimate for rural areas.

**Narrative:**
Approximately 75% of Alaskan communities, including the state's capital city of Juneau, are not connected to the road system, although 3 out of 4 Alaskans live in or near Anchorage, Fairbanks or Juneau. The concentration of children in the remote rural population, especially Native children and in smaller communities outside the regional centers, is striking.

The geographic isolation of rural communities means significant challenges in assuring all MCH populations have access to routine preventive care, acute medical and specialty care. Accessing "nearby health services" or specialized health care means travel by commercial jet, small plane, the state marine ferry system, all terrain vehicles, small boats or snow machines. Some residents may travel distances equivalent to traveling from Washington, D.C. to New Orleans for even routine medical care. Moreover, severe weather can render travel impossible, creating especially critical situations in medical emergencies. Even if ideal health care systems were in place, socio/economic factors create additional barriers for populations living in frontier and remote areas. Compared to urban populations, frontier and remote populations are poorer, lack health insurance, have limited employment opportunities and face cultural or language barriers.

Significant improvements in the health status of natives have been made since the 1970s as a result of investments in village sanitation, housing, and access to health care services and facilities. The addition of federally funded community health centers is also thought to have contributed to improvements in health for women and children, although services for these populations are limited by skill, access to supplies and frequent provider turnover.

**Health Status Indicators 11:** *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|---|---|
| Total Population | 669783.0 |

| | |
|---|---|
| Percent Below: 50% of poverty | 3.6 |
| 100% of poverty | 8.4 |
| 200% of poverty | 22.9 |

**Notes - 2011**
Population for whom poverty status is determined.

**Narrative:**
Rural areas of Alaska have few full-time job opportunities and therefore poverty levels tend to be higher there. Rural residents continue to depend on subsistence hunting and fishing, and incomes are low. Alaska Natives are moving from villages to urban areas for jobs and education opportunities and this may result in higher standards of living, over time, for those families who make the transition. However, the population of remote villages continue to grow despite migration to urban areas.

The Alaska Permanent Dividend continues to be an important source of cash income for many families. It was estimated that without the dividends, twice as many Anchorage residents would have fallen below the federal poverty line in 2000. In 1999, when dividends were close to $2,000 per person, they made up to 15% of per capita income in the Wade Hampton Census Area which has the lowest incomes in the state. (Source: "Understanding Alaska: People, Economy, and Resources". Institute of Social and Economic Research, University of Alaska Anchorage, 2006).

**Health Status Indicators 12:** *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|---|---|
| Children 0 through 19 years old | 176986.0 |
| Percent Below: 50% of poverty | 0.0 |
| 100% of poverty | 8.4 |
| 200% of poverty | 0.0 |

**Notes - 2011**
Data not available.

Data not available.

**Narrative:**
Rural areas of Alaska have few full-time job opportunities and therefore poverty levels tend to be higher there. Rural residents continue to depend on subsistence hunting and fishing, and incomes are low. Alaska Natives are moving from villages to urban areas for jobs and education opportunities and this may result in higher standards of living, over time, for those families who make the transition. However, the population of remote villages continue to grow despite migration to urban areas.

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has the lowest incomes in the state.

(Source: "Understanding Alaska: People, Economy, and Resources". Institute of Social and Economic Research, University of Alaska Anchorage, 2006).

## F. Other Program Activities

The Toll free hotline is combined with the main number for the Title V/CSHCN program. Approximately 20 calls per day come into this number with most callers requesting to talk with one of the staff members. A total of 400 calls were received for state fiscal year 2010 requesting information on specific programs or looking for information regarding services such as WIC, Medicaid, services for children with autism, genetic conditions, breastfeeding, family planning and breast and cervical health check information. The Department of Health and Social Services collaborates with the United Way agency in support of the 211 information systems for the state of Alaska. Specific calls regarding services delivered by agencies are not tracked.

In FY 2010 WCFH staff conducted Strengths, Weaknesses, Opportunities and Threats (SWOT) analyses with the Perinatal Advisory Committee, the Newborn Metabolic Screening Advisory Committee and the Early Hearing and Detection Intervention Advisory Committee. One consistent theme was that collaboration among stakeholders is very high. Another consistent theme was the usefulness and excellent quality of parent navigation services. WCFH has placed considerable effort in establishing advisory committees for all the MCH programs, including a teen advisory committee for the Adolescent Health program. Stakeholders are engaged on a regular basis throughout the year, both formally, via teleconferenced committee meetings, and informally, through emails and listservs. We have adopted the World Café model and SWOT analyses for soliciting input. Feedback from participants indicated that the World Café format worked well for them.

Late in FY 2009, parent support services were added as a program supervised by the Autism Program program manager. During FY 2010, the program manager worked with the Family Voices designee to establish a Family Advisory Committee representing families whose children experience chronic medical conditions or developmental disabilities. Most recently, the program manager has been traveling around the state assessing parent needs and service delivery gaps in the nine communities where Title V funded clinical services are offered. The information will be used to prioritize future program development.

The MCH-Epidemiology Unit published numerous reports, bulletins and peer-reviewed journal articles. The publications list is presented as an attachment, and are available at the MCH-Epidemiology website: http://www.epi.alaska.gov/mchepi/pubs/indexcategory.jsp

***An attachment is included in this section.***

## G. Technical Assistance

# V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

| | FY 2009 | | FY 2010 | | FY 2011 | |
|---|---|---|---|---|---|---|
| | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **1. Federal Allocation** *(Line1, Form 2)* | 1111425 | 1111425 | 1116274 | | 1111425 | |
| **2. Unobligated Balance** *(Line2, Form 2)* | 50000 | 50000 | 75000 | | 0 | |
| **3. State Funds** *(Line3, Form 2)* | 10536682 | 15054095 | 10890461 | | 13657150 | |
| **4. Local MCH Funds** *(Line4, Form 2)* | 0 | 0 | 0 | | 0 | |
| **5. Other Funds** *(Line5, Form 2)* | 0 | 0 | 0 | | 0 | |
| **6. Program Income** *(Line6, Form 2)* | 50000 | 50000 | 50000 | | 50000 | |
| **7. Subtotal** | 11748107 | 16265520 | 12131735 | | 14818575 | |
| **8. Other Federal Funds** *(Line10, Form 2)* | 4179892 | 4179892 | 4442184 | | 4714559 | |
| **9. Total** *(Line11, Form 2)* | 15927999 | 20445412 | 16573919 | | 19533134 | |

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

| | FY 2009 | | FY 2010 | | FY 2011 | |
|---|---|---|---|---|---|---|
| **I. Federal-State MCH Block Grant Partnership** | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **a. Pregnant Women** | 701102 | 2058723 | 811541 | | 1839809 | |
| **b. Infants < 1 year old** | 1272224 | 2058193 | 1043137 | | 2265917 | |
| **c. Children 1 to 22 years old** | 1840278 | 1384725 | 1633791 | | 1421506 | |
| **d. Children with** | 6815840 | 8581654 | 7244628 | | 7560248 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Special Healthcare Needs** | | | | | | |
| **e. Others** | 456052 | 1454649 | 548706 | | 925441 | |
| **f. Administration** | 662611 | 727576 | 849932 | | 805654 | |
| **g. SUBTOTAL** | 11748107 | 16265520 | 12131735 | | 14818575 | |
| **II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).** | | | | | | |
| **a. SPRANS** | 0 | | 0 | | 0 | |
| **b. SSDI** | 100000 | | 94644 | | 93713 | |
| **c. CISS** | 0 | | 0 | | 0 | |
| **d. Abstinence Education** | 0 | | 0 | | 0 | |
| **e. Healthy Start** | 0 | | 0 | | 0 | |
| **f. EMSC** | 0 | | 0 | | 0 | |
| **g. WIC** | 0 | | 0 | | 0 | |
| **h. AIDS** | 0 | | 0 | | 0 | |
| **i. CDC** | 3287129 | | 2976090 | | 3169602 | |
| **j. Education** | 0 | | 0 | | 0 | |
| **k. Other** | | | | | | |
| **HRSA-other funds** | 0 | | 0 | | 830136 | |
| **Title X-Family Plann** | 0 | | 0 | | 621108 | |
| **HRSA other** | 0 | | 750342 | | 0 | |
| **Title X-Family Plan.** | 434247 | | 621108 | | 0 | |
| **HRSA-various** | 358516 | | 0 | | 0 | |

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

| | FY 2009 | | FY 2010 | | FY 2011 | |
|---|---|---|---|---|---|---|
| | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **I. Direct Health Care Services** | 570393 | 2662043 | 1213174 | | 1986923 | |
| **II. Enabling Services** | 4711803 | 4495258 | 4610059 | | 4621808 | |
| **III. Population-Based Services** | 2015743 | 3223629 | 2426347 | | 3171187 | |
| **IV. Infrastructure Building Services** | 4450168 | 5884590 | 3882155 | | 5038657 | |
| **V. Federal-State Title V Block Grant Partnership Total** | 11748107 | 16265520 | 12131735 | | 14818575 | |

## A. Expenditures

/2011/Spending in FFY2009 was more than budgeted as a result of additional funds received for MCH programs located in other divisions including behavioral health and the Women's, Infant and Children's Nutrition program. Additional Medicaid funding was received in the Title V program to support school age children and outreach for EPSDT as well as data analysis conducted by the MCH epidemiological staff for the Medicaid program. Additional funding from the Mental Health Trust Authority was received to support expansion of the autism diagnostic clinics and training in rural and remote communities. Two additional communities hosted screening clinics for children

suspected with autism or other neurodevelopmental disorders. Early screening and referral enabled these children to be referred to the Providence Autism Diagnostic Network for a interdisciplinary diagnostic evaluation  intensive intervention services for children diagnosed with autism. Additional funding was recieved to support development of formalized academic training paths leading to a occupational endorsement or degree in areas that support intensive intervention for children diagnosed with autism. //2011//

## B. Budget

/2011/ The budget for FFY2011 is anticipated to be slightly increased as a result of an increase in general funds from the state in support of general infrastructure, autism workforce development and ongoing support of of the Alaska birth defects and FASD surveillance systems. This later program is a statutorily required program which has relied exclusively on MCH Title V Block grant funding for the last 5 years. Receipt of general funds dollars will assist in shifting block grant funding to support programs for school health, school nursing and outreach of EPSDT screening. Additional expenditures are budgeted for CYSHCN in support of transition to adulthood and expansion of specialty clinics for screening of autism and neurodevelopmental disorders to 9 additional communities. The Title V program consistently looks for ways to braid and blend funding for new and existing programs to assure an ongoing plan for sustainability. A slight increase in federal funding for the Title V program is expected due to new and supplemental grants applied for in the areas of Teen Pregnancy Prevention, Home Visiting and a Healthy Start Grant. //2011//

## VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

## VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. Technical Note
Please refer to Section IX of the Guidance.

## X. Appendices and State Supporting documents
### A. Needs Assessment
Please refer to Section II attachments, if provided.

### B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

### C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

### D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.